

Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair

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[Instructions for Use](#)

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Coverage Rationale

Indications for Coverage

Some states require benefit coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external Congenital Anomalies in the absence of a Functional Impairment. Refer to the member specific benefit plan document.

Criteria for a Coverage Determination that Surgery is Reconstructive and Medically Necessary

The following must be available when requested by UnitedHealthcare:

- Best corrected visual acuity in both eyes, all members (except pediatrics)
- Eye exam (chief complaint, HPI)
- Clear, high-quality, clinical photographs (eye level, frontal with the member looking straight ahead, light reflex visible and centered)
- Peripheral or superior [Visual Fields](#) automated, reliable, un-taped/taped are preferable
 - In situations where computerized Reliable Visual Field testing is not available, we will accept manual Reliable Visual Field testing
 - In situations where Reliable Visual Field testing is not possible, see section below titled [When the Member is Not Capable of Reliable Visual Field Testing](#)

Note: The Visual Fields and high-quality, clinical photographs must be consistent.

If multiple procedures are requested, the following criteria must be met:

- All criteria for each individual procedure must be met; and
- Reliable Visual Field testing shows visual impairment which can't be addressed by one procedure alone; and
- High-quality, clinical photograph findings are consistent with Visual Field findings

Upper eyelid blepharoplasty (CPT 15822 and 15823) is considered reconstructive and medically necessary when the following criteria are present:

- Ptosis has been ruled out as the primary cause of Visual Field obstruction; and
- Clear, high-quality, clinical photographs must show that the extra skin is the primary cause of Visual Field obstruction; and
- The member must have a Functional or Physical Impairment complaint directly related to an abnormality of the eyelid(s); and

- Excess skin (dermatochalasis/blepharochalasis) touches the lashes; and
- Automated peripheral or superior Reliable Visual Field testing, with the eyelid skin taped and un-taped, showing improvement of 30% (or 12 degrees) or more.
 - In situations where computerized Reliable Visual Field testing is not available, we will accept manual Reliable Visual Field testing
 - In situations where Reliable Visual Field testing is not possible, see section below titled [When the Member is Not Capable of Reliable Visual Field Testing](#)

Note: Extended blepharoplasty may be indicated for blepharospasm (eyelids are forced shut) when the following two criteria are met:

- Debilitating symptoms (e.g., pain); and
- Conservative treatment has been tried and failed, or is contraindicated (e.g., Botox®)

Upper eyelid blepharoptosis repair (CPT 67901–67909) is considered reconstructive and medically necessary when the following criteria are present:

- The member must have a Functional or Physical Impairment complaint directly related to the position of the eyelid(s); and
- Other treatable causes of ptosis are ruled out (e.g., recent Botox® injections, myasthenia gravis when applicable); and
- Eyelid droop (upper eyelid ptosis) and a Marginal Reflex Distance -1 (MRD-1) of 2.0 mm or less; and
- The MRD is documented in clear, high-quality, clinical photographs with the member looking straight ahead and light reflex centered on the pupil; and
- Automated peripheral or superior Reliable Visual Field testing, with the eyelids taped and un-taped, showing improvement of 30% (or 12 degrees) or more improvement in the number of points seen
 - In situations where computerized Reliable Visual Field testing is not available, we will accept manual Reliable Visual Field testing
 - In situations where Reliable Visual Field testing is not possible, see section below titled [When the Member is Not Capable of Reliable Visual Field Testing](#)

Note: For children under age 10 years, ptosis repair is covered to prevent amblyopia. Reliable Visual Field testing is not required, but high-quality, clinical photographs are required.

Brow ptosis (CPT 67900) is considered reconstructive and medically necessary when the following criteria are present:

- Other causes have been eliminated as the primary cause for the Visual Field obstruction (e.g., Botox® treatments within the past six (6) months); and
- The member must have a functional complaint related to brow ptosis. Brow ptosis must be documented in two high-quality, clinical photographs. One showing the eyebrow below the bony superior orbital rim, and a second photograph with the brow elevated that eliminates the Visual Field defect; and
 - Automated peripheral and superior Reliable Visual Field testing, with differential taping (eyebrow and eyebrow + eyelid) showing 30% (or 12 degrees) or more improvement in total number of points seen with the eyebrow taped up. In situations where computerized Reliable Visual Field testing is not available, we will accept manual Reliable Visual Field testing
 - In situations where Reliable Visual Field testing is not possible, see section below titled [When the Member is Not Capable of Reliable Visual Field Testing](#)
- Documentation indicating the specific brow lift procedure (e.g., supra-ciliary, mid forehead or coronal, pretrichial, direct brow lift vs browpexy, internal brow lift)

Brow ptosis repair (CPT 67900) as an adjunct to upper eyelid blepharoplasty (CPT 15822 and 15823) is considered reconstructive and medically necessary when the criteria for each separate service are met (as per above) and:

- Automated peripheral and superior Reliable Visual Field testing demonstrates the following:
 - Differential taping showing 30% (or 12 degrees) or more improvement in total number of points seen with the eyelid taped up and an additional 30% (or 12 degrees) or more improvement in total number of points seen with the eyelid + eyebrow taped up, confirming the contribution of brow ptosis to visual field obstruction

Note: For Browpexy/internal brow lift, see [Coverage Limitations and Exclusions](#).

Eyelid surgery for correction of lagophthalmos is considered reconstructive and medically necessary when the upper eyelid is not providing complete closure to the eye, resulting in dryness and other complications.

Eyelid surgery with an anophthalmic socket (has no eyeball) is considered reconstructive and medically necessary when both of the following criteria are present:

- The member has an anophthalmic condition; and
- The member is experiencing difficulties fitting or wearing an ocular prosthesis.

Lower eyelid blepharoplasty (CPT 15820 and 15821) is usually cosmetic, however, is considered reconstructive and medically necessary only when all of the following criteria are present:

- There is documented facial nerve damage; and
- Clear, high-quality, clinical photographs document the pathology; and
- The member is unable to close the eye due to the lower lid dysfunction; and
- Functional Impairment including both of the following:
 - Documented uncontrolled tearing or irritation; and
 - Conservative treatments tried and failed

Ectropion (eyelid turned outward) (CPT 67914 through 67917) or punctal eversion is considered reconstructive and medically necessary when all of the following criteria are present:

- Clear, high-quality, clinical photographs document the pathology; and
- Corneal or conjunctival injury with both of the following criteria:
 - Subjective symptoms include either:
 - Pain or discomfort; or
 - Excess tearing; and
 - Any one of the following:
 - Exposure keratitis; and/or
 - Keratoconjunctivitis; and/or
 - Corneal ulcer

Entropion (eyelid turned inward) (CPT 67921–67924) is considered reconstructive and medically necessary when all of the following criteria are present:

- Clear, high-quality, clinical photographs must document the following:
 - Lid turned inward; and
 - At least one of the following:
 - Trichiasis; or
 - Irritation of cornea or conjunctiva; and
 - Subjective symptoms including either of the following:
 - Excessive tearing; or
 - Pain or discomfort

Lid retraction surgery (CPT 67911) is considered reconstructive and medically necessary when all of the following criteria are present:

- Other causes have been eliminated as the reason for the lid retraction such as use of dilating eye drops, glaucoma medications; and
- Clear, high-quality, clinical photographs document the pathology; and
- There is Functional Impairment (such as ‘dry eyes’, pain/discomfort, tearing, blurred vision); and
- Tried and failed conservative treatments; and
- In cases of thyroid eye disease two or more Hertel measurements at least 6 months apart with the same base measurements are unchanged

Canthoplasty/canthopexy (CPT 21280, 21282, 67950, 67961, 67966) is considered reconstructive and medically necessary when all of the following criteria are present:

- Functional Impairment; and
- Clear, high-quality, clinical photographs document the pathology; and
- Repair of ectropion or entropion will not correct condition; and

- At least one of the following is present:
 - Epiphora (excess tearing) not resolved by conservative measures; or
 - Corneal dryness unresponsive to lubricants; or
 - Corneal ulcer

Repair of Floppy Eyelid Syndrome (FES) (CPT 67961 and 67966) is considered reconstructive and medically necessary when all of the following are present when documented and confirmed by history and examination:

- Subjective symptoms must include eyelids spontaneously "flipping over" when the member sleeps due to rubbing on the pillow, and one of the following:
 - Eye pain or discomfort; or
 - Excess tearing; or
 - Eye irritation, ocular redness and discharge.
- Physical Examination that documents the following:
 - Eyelash Ptosis; and
 - Significant upper eyelid laxity; and
 - Presence of Giant Papillary Conjunctivitis; or
 - Corneal findings such as:
 - Superficial Punctate Erosions (SPK); or
 - Corneal abrasion (documentation of a history of corneal abrasion or recurrent erosion syndrome is considered sufficient); or
 - Microbial Keratitis
- Clear, high-quality, clinical photographs that clearly document Floppy Eyelid Syndrome and demonstrate both of the following:
 - Lids must be everted in the photographs; and
 - Conjunctival surface (underbelly) of the lids must clearly demonstrate giant papillary conjunctivitis
- Documentation that conservative treatment has been tried and failed. Examples may include:
 - Ocular lubricants both drops (daytime) and ointments (bedtime); or
 - Short trial of antihistamines; or
 - Topical steroid drops; or
 - Eye Shield and/or Taping the lids at bedtime
- Other causes of the eye findings have been ruled out. Examples may include:
 - Allergic conjunctivitis
 - Atopic keratoconjunctivitis
 - Blepharitis
 - Contact lens (CL) complication
 - Dermatochalasis
 - Ectropion
 - Giant Papillary Conjunctivitis (GPC) that is not related to FES
 - Ptosis of the lid(s)
 - Superior limbic keratoconjunctivitis (SLK)

When the Member is Not Capable of Reliable Visual Field Testing

Reliable Visual Field testing is not required when the member is not capable of performing a Visual Field test. The following are some examples:

- If the member is a child 12 years old or under
- If the member has intellectual disabilities (previously known as mental retardation) or some other severe neurologic disease

Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

- Procedure that do not meet the reconstructive criteria above in the [Indications for Coverage](#) section.
- Browpexy/internal brow lift is not designed to improve function.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair	
15820, 15821, 15822, 15823, 21280, 21282, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67912, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67950, 67961, 67966	<p>Medical notes documenting the following, when applicable:</p> <ul style="list-style-type: none"> • Planned procedure • Results of automated or manual, taped and un-taped, Reliable Visual Field testing • Marginal reflex distance (MRD-1) • Visual complaints, functional impairments and ruling out other causes • High-quality photograph(s); all photos must be full face, labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) <p>Note: Submission of color photos can be submitted via the external portal at www.uhcprovider.com/paan; faxes of color photos will not be accepted</p>

*For code descriptions, see the [Applicable Codes](#) section.

Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Cosmetic Procedures (California only): Procedures or services are performed to alter or reshape normal structures of the body in order to improve your appearance.

Floppy Eyelid Syndrome (FES): Characterized by significant upper eyelid laxity and chronic papillary conjunctivitis in upper palpebral conjunctiva that is poorly respondent to topical lubrication and steroids. FES is known to be associated with obesity, obstructive sleep apnea, Down syndrome, and keratoconus. Keratoconus can be linked to frequent rubbing and mechanical effect on the palpebral conjunctiva and cornea.

Functional or Physical or Physiological Impairment: Functional or Physical or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Giant Papillary Conjunctivitis: Is defined by exam findings of giant papillary hypertrophy primarily affecting the upper tarsal conjunctiva.

Marginal Reflex Distance -1 (MRD-1): Measures the number of millimeters from the corneal light reflex or center of the pupil to the upper lid margin. (Note: The “-1” in MRD-1 refers to the upper lid and not the measurement in millimeters.)

Marginal Reflex Distance -2 (MRD-2): Measures the number of millimeters from the corneal light reflex or center of the pupil to the lower lid margin. (Note: The “-2” in MRD-2 refers to the lower lid and not the measurement in millimeters.)

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Reconstructive Procedures (California only): Reconstructive Procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- To improve function.
- To create a normal appearance, to the extent possible.

Reconstructive Procedures include surgery or other procedures which are related to a health condition. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Care Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Reliable (Visual Fields): The reliability of the visual fields is indicated in the visual field report with the number of fixation losses, false negative and false positives. A reliable visual field has less than 30% or fewer of fixation losses, false negative and false positives.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health care service. Benefit coverage for health care services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Note: The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.

CPT Code	Description
Blepharoplasty (Lower Eyelid)	
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
Blepharoplasty (Upper Eyelid)	
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid

CPT Code	Description
Brow Ptosis Repair	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
Upper Eyelid Blepharoptosis Repair	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
Lid Retraction	
67911	Correction of lid retraction
Lagophthalmos	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
Ectropion	
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)
Entropion	
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)
Canthus Repair and Lid Repair	
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
67950	Canthoplasty (reconstruction of canthus)
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin
67966	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
Floppy Eyelid Syndrome	
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin
67966	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin

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Guideline History/Revision Information

Date	Summary of Changes
01/01/2021	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Added language to indicate eyelid surgery for correction of lagophthalmos is considered reconstructive and medically necessary when the upper eyelid is not providing complete closure to the eye, resulting in dryness and other complications <p>Documentation Requirements</p> <ul style="list-style-type: none"> Updated list of CPT codes with associated documentation requirements; added 67912 Updated list of applicable documentation requirements: <ul style="list-style-type: none"> Added language to indicate medical notes must document the “planned procedure” Modified language addressing required detail for Reliable Visual Field testing <p>Applicable Codes</p> <ul style="list-style-type: none"> Added CPT code 67912 <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version CDG.002.17

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.