Blepharoplasty, Blepharoptosis, and Brow Ptoisis Repair (for Mississippi Only)

Guideline Number: CS008MS.T
Effective Date: August 1, 2021

Application

This Coverage Determination Guideline only applies to the state of Mississippi.

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.

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, untaped/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
Lower eyelid blepharoplasty (CPT codes 15820 and 15821) is usually cosmetic, however, is considered reconstructive and medically necessary under certain circumstances. For medical necessity clinical coverage criteria, refer to the Mississippi Division of Medicaid, Administrative Code, Title 23: Medicaid, Part 203, Physician Services.

Upper eyelid blepharoplasty (CPT codes 15822 and 15823) is considered reconstructive and medically necessary under certain circumstances. For medical necessity clinical coverage criteria, refer to the Mississippi Division of Medicaid, Administrative Code, Title 23: Medicaid, Part 203, Physician Services.

Brow ptosis repair (CPT code 67900) and upper eyelid blepharoptosis repair (CPT codes 67901-67909) is considered reconstructive and medically necessary under certain circumstances. For medical necessity clinical coverage criteria, refer to the Mississippi Division of Medicaid, Administrative Code, Title 23: Medicaid, Part 203, Physician Services.

Note: For browpexy/internal brow lift, refer to the 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

Ectropion (eyelid turned outward) (CPT codes 67914-67917) 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
- Conjunctival 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 codes 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 code 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 codes 21280, 21282, 67950, 67961, and 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 codes 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/or
  - 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 be clearly visible
- Documentation that a 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
*Submission of High-Quality Photograph(s)*

All photographs must be full face and labeled with:
- Date taken
- Applicable case number obtained at time of notification, or the member’s name and ID number on the photograph(s)

Note: Submission of color photograph(s) can be submitted via the external portal at [www.uhcp.com/paan](http://www.uhcp.com/paan); faxes of color photos will not be accepted.

**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.
- Procedures that do not meet the reconstructive criteria above in the *Indications for Coverage* section.
- Browpexy/internal brow lift is not designed to improve function.

**Definitions**

Check the definitions within the member benefit plan document that supersede the definitions below.

**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.

**Floppy Eyelid Syndrome (FES)**: Is 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**: A 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.

**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 policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements 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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive herniated fat pad</td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
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<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)</td>
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<tr>
<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67908</td>
<td>Repair of blepharoptosis; conjunctivo-tarso-Muller’s muscle-levator resection (e.g., Fasanella-Servat type)</td>
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<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
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<td>67911</td>
<td>Correction of lid retraction</td>
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<td>67912</td>
<td>Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)</td>
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<td>67914</td>
<td>Repair of ectropion; suture</td>
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<td>67915</td>
<td>Repair of ectropion; thermocauterization</td>
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<tr>
<td>67916</td>
<td>Repair of ectropion; excision tarsal wedge</td>
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<tr>
<td>67917</td>
<td>Repair of ectropion; extensive (e.g., tarsal strip operations)</td>
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<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
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<tr>
<td>67922</td>
<td>Repair of entropion; thermocauterization</td>
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<tr>
<td>CPT Code</td>
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<tr>
<td><strong>Entropion</strong></td>
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<tr>
<td>67923</td>
<td>Repair of entropion; excision tarsal wedge</td>
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<tr>
<td>67924</td>
<td>Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)</td>
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<tr>
<td><strong>Canthus Repair and Lid Repair</strong></td>
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<tr>
<td>21280</td>
<td>Medial canthopexy (separate procedure)</td>
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<tr>
<td>21282</td>
<td>Lateral canthopexy</td>
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<tr>
<td>67950</td>
<td>Canthoplasty (reconstruction of canthus)</td>
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<td>67961</td>
<td>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</td>
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<td>67966</td>
<td>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</td>
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<td><strong>Floppy Eyelid Syndrome</strong></td>
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References


Guideline History/Revision Information

<table>
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<tr>
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<th>Summary of Changes</th>
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<tr>
<td>08/01/2021</td>
<td><strong>Application</strong></td>
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<tr>
<td></td>
<td>- Created state-specific policy version for Mississippi</td>
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<td><strong>Coverage Rationale</strong></td>
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<td>- Replaced coverage guidelines with instruction to refer to the <em>Mississippi Administrative Code Title 23: Medicaid, Part 203, Physician Services</em> for medical necessity clinical coverage criteria for the following:</td>
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<tr>
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<td>- Brow ptosis repair and upper eyelid blepharoptosis repair</td>
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<td></td>
<td>- Lower eyelid blepharoplasty</td>
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<td></td>
<td>- Upper eyelid blepharoplasty</td>
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<td><strong>Supporting Information</strong></td>
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<td></td>
<td>- Updated <em>References</em> section to reflect the most current information</td>
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<td>- Archived previous policy version CS008.S</td>
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</table>

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The 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.