Brow Ptosis and Eyelid Repair (for Ohio Only)

Policy Number: CS008OH.D
Effective Date: December 1, 2025

➲ Instructions for Use

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Related Policy

- Cosmetic and Reconstructive Procedures (for Ohio Only)

Application

This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

Note: The InterQual® criteria below only applies to persons 18 years of age and older.

Brow ptosis repair and repair of the eyelid are considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:

- Blepharoplasty
- Ectropion Repair
- Entropion Repair
- Eyelid Lesion Excision, +/- Reconstruction
- Eyelid Reconstruction
- Ptosis Repair

Click here to view the InterQual® criteria.

Note: If multiple procedures are requested, criteria for each individual procedure must be met.

Internal Browpexy for any condition is considered cosmetic and not medically necessary.

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.

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
- There is a functional impairment (e.g., '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, and 67950) are considered reconstructive and medically necessary when all of the following criteria are present:

- There is a functional impairment; 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 and have been 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 all of the following:
  - **Both** of the following:
    - Eyelash ptosis; and
    - Significant upper eyelid laxity

    and
  - **One** of the following:
    - Presence of giant papillary conjunctivitis (GPC); or
    - Corneal findings such as one of the following:
      - 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 conservative treatment has been tried and failed; examples may include:
  - Ocular lubricants both drops (daytime) and ointments (bedtime)
  - Short trial of antihistamines
  - Topical steroid drops
  - Eye shield and/or taping the lids at bedtime
- Infections of the eye have been ruled out; examples may include:
  - Allergic conjunctivitis
  - Atopic keratoconjunctivitis
  - Blepharitis
  - Contact lens (CL) complication [e.g., Giant Papillary Conjunctivitis (GPC)]
  - Superior limbic keratoconjunctivitis (SLK)

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

Definitions

Refer to the federal, state, and contractual definitions that supersede the definitions below.

Canthopexy: A surgical technique for lid malposition that involves securing the lateral retinaculum to the periosteum of the superolateral orbital rim with a suture (Rizvi 2010).

Canthoplasty: A procedure that is indicated for a variety of eyelid conditions. It is applicable to any disruption to the normal architecture of the canthus which can lead to negative functional sequelae (AAO 2023).

Floppy Eyelid Syndrome (FES): A frequent eyelid disorder characterized by eyelid laxity that determines a spontaneous eyelid eversion during sleep associated with chronic papillary conjunctivitis and systemic diseases (DeGregorio, 2021).

Internal Browpexy: A minimally invasive technique to provide stabilization and subtle elevation of the lateral brow (Karimi et al., 2020).

Lagophthalmos: The inability to close the eyelids completely. A portion of the eye remains open during a blink and during sleep and is subject to damage from exposure (AAO Exposure Keratopathy, 2024).

Marginal Reflex Distance - 1 (MRD-1): The measurement in millimeters from the light reflex on the patient's cornea to the upper eyelid margin with the patient gazing in the primary position. MRD1 is used to indicate degree of ptosis or retraction (AAO 2023).

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.

CPT Code	Description
Blepharoplasty (Lower and Upper Eyelid)	
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
Brow Ptosis Repair	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
Canthoplasty/Canthopexy	
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
Ectropion and Entropion	
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization

CPT Code	Description
Ectropion and Entropion	
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)
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)
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
Lagophthalmos	
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)
Lid Retraction	
67911	Correction of lid retraction
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

Clinical Evidence

Internal Browpexy

An internal browpexy is best for mild brow ptosis, which is considered cosmetic. It is difficult to generate a substantial amount of elevation using this technique (Shaw and Phelps, 2020).

In a 2023 objective comparison of eyebrow position following internal and external browpexy, Huang et al. retrospectively reviewed the cases of 68 patients, mostly females, who underwent either internal browpexy (39), external browpexy (9) or upper eyelid skin excision alone (20). Photographs were taken before, immediately after surgery, then at one week, one-three months, four-six months and seven-12 months. Brow height changes were measured using the ImageJ biological measuring program and compared among the three groups. The results showed both internal and external browpexy provided improvement within 3 months of surgery, however outcomes for those treated with an external browpexy had better brow-lift outcomes across the entire brow than did internal browpexy. The authors concluded that external browpexy is a better choice for those with severe whole brow ptosis, and internal browpexy is recommended for patients with mild ptosis. This retrospective observational study is limited by a small number of participants and a lack of randomization. Furthermore, most patients were lost to follow up so longer term data is not available. Further high quality research is needed to validate these findings.

Floppy Eyelid Syndrome (FES)

There is no diagnostic test for FES. It is a clinical diagnosis based on history, symptoms and as a sequelae of systemic conditions, such as obstructive sleep apnea (OSA) and morbid obesity. The eye disorder keratoconus may also contribute to FES. Individuals with this condition should be managed with an internal medicine team and a sleep disorder specialist. Addressing obesity, OSA and avoiding sleeping in a prone position may improve symptoms. If there is minimal response to these interventions, surgical procedures such as horizontal eyelid shortening can help to relieve ocular symptoms and provide good functional and cosmetic results. Surgery should be considered in significantly symptomatic patients after controlling ocular surface disease and optimizing medical status (AAO).

Several systematic review and meta-analyses have explored the association of FES and OSA (Aiello et al., 2023; Cheong et al., 2023; Bulloch et al.,2023) and concluded that there is an association between the two, with the severity of OSA correlating to higher incidence of FES.

Cheong et al. (2023) conducted a systematic review and meta-analysis to investigate the relationship between obstructive sleep apnea (OSA) and FES. The systematic review included 12 studies, nine of which were included in the meta-analysis, with a total of 1,109 individuals. The analysis of the data determined a significant association between OSA and FES (OR = 1.89, 95% CI = 1.27-2.83, I 2 = 44%). Upon further investigation the study determined the more severe the OSA, the higher the risk of developing FES. Patients with severe OSA had the highest risk of developing FES (OR = 3.06, 95% CI = 1.62-5.78, I 2 = 0%), followed by moderate OSA (OR = 2.53, 95% CI = 1.29-4.97, I 2 = 0%), and patients with mild OSA had the lowest risk (OR = 1.76, 95% CI = 0.85-3.62, I 2 = 0%). The authors concluded there was a positive association between OSA and FES with increasing severity of OSA correlating with significantly higher risk of FES. Limitations in the study were important covariates such as age, gender and body mass index were not adjusted. The authors recommend more longitudinal studies with sufficient duration of follow-up to better characterize the relationship between OSA and FES.

Acar et al. (2021) conducted a randomized controlled trial (RCT) of 51 individuals with obstructive sleep apnea hypopnea syndrome (OSAHS) to assess the long-term effects of positive airway pressure (PAP) therapy on the eyelid and the ocular surface. Over a period of 18 months individuals were treated with PAP, and the scores were compared for the pre- and post-PAP values for eye examination which included the presence of FES, ocular surface disease index (OSDI) questionnaire results, Schirmer I test, tear film breakup time (TBUT), and corneal staining. The presence of FES before and after PAP was 56.9% and 74.5% ($p < 0.01$). FES stage was determined as 1.41 ±0.98 before PAP and 0.78 ±0.78 after PAP ($p < 0.01$). Pre-PAP and post-PAP ocular surface disease index OSDI results were 47.79 ±21.04 and 42.17 ±19.97, ($p < 0.01$). Schirmer values before and after PAP were 7.23 ±1.95 and 8.49 ±1.79 mm, ($p < 0.01$). TBUT values before and after PAP were 7.11 ±1.82 and 8.68 ±1.76 seconds, ($p < 0.01$). Scores of the corneal staining stages before and after PAP were 1.05 ±0.75 and 0.68 ±0.54, ($p < 0.01$). The authors concluded OSAHS was associated with low Schirmer and TBUT values, high scores on the OSDI questionnaire, and high corneal staining. Normal sleep patterns returned after appropriate use of PAP along with relief of systemic findings and ocular surface problems. The authors believe long term use of PAP (at least one year) improves FES and overcomes the problem of ocular irritation that occurs in the early stage of PAP therapy. Limitations of the study include lack of blinding when performing the ocular screenings and small sample size.

Lagophthalmos

Proper eyelid closure and a normal blink reflex are essential to maintaining a stable tear film and a healthy corneal surface. Patients affected with lagophthalmos are unable to fully close their eyelids, and they may describe symptoms of dry and irritated eyes. Common morbidities of lagophthalmos are corneal exposure and subsequent keratopathy, which may progress to corneal ulceration and infectious keratitis. It is important to recognize lagophthalmos early in the patient's course and begin treatment as soon as possible. The choice of therapy requires an understanding of both the etiology and expected duration of the lagophthalmos. The etiology of lagophthalmos is due to damage to the facial nerve which can be from trauma, stroke, Bell's palsy, tumors, Möbius' syndrome and infections or immune-mediated causes. Medical treatment and supportive care includes artificial tears and ointments, moisture goggles and patches. Surgical treatments include tarsorrhaphy and the implantation of gold weights, upper and lower eyelid retraction, upper eyelid levator muscle recession and lower eyelid elevation. Treatment is done in a stepwise approach based on the severity and duration of the condition (AAO 2008).

Lid Retraction Surgery

Upper eyelid retraction is defined by abnormally high resting position of the upper lid. This produces visible sclera between the eyelid margin and corneal limbus, which produces the appearance of a stare with an accompanying illusion of exophthalmos. Eyelid retraction can lead to lagophthalmos and exposure keratitis, which can cause mild ocular surface irritation to vision-threatening corneal decompensation. The most common cause is thyroid eye disease (TED), and may

also be congenital, neurogenic or myogenic in nature. Mild upper eyelid retraction in TED can resolve spontaneously over time, and if it does not, or the condition is causing an immediate threat to the cornea or vision, tarsorrhaphies or recession of the upper eyelid are surgical treatments. Other treatments when surgery is not an option include transconjunctival Botulinum toxin A injections, triamcinolone acetonide deep fornix and subconjunctival injections and hyaluronic acid filler subconjunctival injections (AAO, 2023).

Lower eyelid retraction is a malposition of the lower eyelid in which the lid margin is displaced inferiorly resulting in increased exposure of the surface of the eye to the environment. It is seen unilaterally and bilaterally depending on the etiology. It most frequently presents due to TED, however it can also be caused by other myogenic, neurogenic, mechanical and congenital conditions. Mild cases may be managed with ocular surface lubrication and more severe cases with grafting (AAO, 2024).

Hoang T et al. (2022) completed an update on the clinical management of Graves' disease and thyroid eye disease (TED). General treatment of patients with TED includes reversal of hyperthyroidism, monitoring for and prompt treatment of hypothyroidism, and cessation of smoking, if applicable. First-line therapy for individuals with moderate to severe TED would include intravenous glucocorticoids. Surgery for TED is typically performed either emergently, such as for optic neuropathy, globe subluxation, or corneal thinning/perforation due to exposure keratopathy, or for rehabilitation after the disease has run its active course. Eyelid changes due to TED are common and include upper and lower eyelid retraction and eyelid fat compartment expansion. Eyelid retraction surgery is aimed at lowering the upper eyelid and raising the lower eyelid to correct the "thyroid stare" appearance. Eyelid contouring is targeted to restore the natural height and contour of the eyelid, including decreasing the fat compartment expansion and minimizing the temporal flare, which occur as part of the disease state. Eyelid surgery is typically the last step in the rehabilitation of the patient's appearance. The total time between onset of TED to the final eyelid surgery can span several years.

Hodgson and Rajaii (2020) conducted a systematic review on the pathophysiology and treatment options for the management of thyroid associated orbitopathy (TAO). TAO also known as Graves' orbitopathy (GO) and thyroid eye disease (TED) is associated with distinct clinical features, including upper eyelid retraction, restrictive strabismus, and proptosis. Moderate to severe TAO is defined as lid retraction > 2 mm, exophthalmos > 3 mm, moderate to severe soft tissue involvement, and presence of diplopia. Sight-threatening TAO is defined as presence of direct optic neuropathy or corneal breakdown. Rehabilitative surgical options include orbital decompression for severe proptosis, strabismus surgery, followed by upper and lower lid retraction surgery. The authors concluded surgical management is required in cases of severe vision-threatening disease that is refractory to medical management, and as restorative treatment when the disease is inactive and clinical measurements are stable. Limitations to the study are small sample sizes and non-randomized methodology.

Medial and Lateral Canthoplasty/Canthopexy

Clinical Practice Guidelines

American Academy of Ophthalmology (AAO) 2008

- Indications for functional canthoplasty:
  - Congenital and involutional entropion
  - Congenital, involutional, and cicatricial ectropion
- Lid laxity (seen with anophthalmos or enophthalmos, and facial nerve palsy)
- Canthal dystopia
- Exposure keratopathy
- Epiphora
- Vertical eyelid retraction [due to trauma, after blepharoplasty, with thyroid eye disease (contraindicated if significant proptosis)]
- Repair after Iatrogenic damage or trauma
- In conjunction with blepharoplasty:
  - To prevent ectropion or eyelid retraction
  - Festoons
- Delayed repair resulting in rounding of the canthus
- Telecanthus
- Congenital malposition or occlusion of the visual field
- Absent naso-orbital valley
- With lateral orbitotomy:
  - In orbital decompression
  - Removal of orbital tumors

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Brow ptosis repair and eyelid repair are procedures and, therefore, not regulated by the FDA. However, devices and instruments used during the surgery may require FDA approval. Refer to the following website for additional information: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed May 2, 2025)

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Policy History/Revision Information

Date	Summary of Changes

12/01/2025	**Medical Records Documentation Used for Reviews**
	• Removed reference link to the guidelines titled *Medical Records Documentation Used for Reviews*
	• Added language to indicate:
	  ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services
	  ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures
	  ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request
	Supporting Information
	• Archived previous policy version CS008OH.C

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]) or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC) or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC) or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC) or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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