

# BLEPHAROPLASTY, BLEPHAROPTOSIS AND BROW PTOSIS REPAIR

**Policy Number:** SURGERY 018.28 T2

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Related Policy
<ul style="list-style-type: none"> <li>• <a href="#">Cosmetic and Reconstructive Procedures</a></li> </ul>

## INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care 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.

## CONDITIONS OF COVERAGE

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General Benefits Package
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes
Precertification with Medical Director Review Required	Yes <sup>1</sup>
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	All
Special Considerations	<sup>1</sup> Precertification with review by a Medical Director or their designee is required.

## BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

## **Essential Health Benefits for Individual and Small Group**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

## **COVERAGE RATIONALE**

### **Indications for Coverage**

Some states require benefit coverage for services that Oxford considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please 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 Oxford:

- Best corrected visual acuity in both eyes, all patients (except pediatrics).
  - Eye exam (chief complaint, HPI).
  - Clear high-quality, clinical photographs (eye level, frontal with patient looking straight ahead, light reflex visible and centered).
  - Peripheral or superior Visual Fields automated, Reliable (see [Definitions](#) below), untaped/taped are preferable.  
**Note the following:**
    - In situations where computerized Visual Field testing is not available, we will accept manual Visual Field testing.
    - In situations where Visual Field testing is not possible, see section below: [When Patient is Not Capable of 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**
- Visual Field testing shows visual impairment which cannot 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 patient must have a Functional/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 Visual Field testing, with the eyelid skin taped and untaped, showing improvement of 30% or more.
  - In situations where computerized Visual Field testing is not available we will accept manual Visual Field testing.
  - In situations where Visual Field testing is not possible, see section below: [When Patient is Not Capable of 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 patient must have a Functional/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 patient looking straight ahead and light reflex centered on the pupil; **and**

- Automated peripheral or superior Visual Field testing, with the eyelids taped and untaped, showing improvement of 30% or more improvement in the number of points seen.
  - In situations where computerized Visual Field testing is not available we will accept manual Visual Field testing.
  - In situations where Visual Field testing is not possible, see section below: [When Patient is Not Capable of Visual Field Testing.](#)

**Note:** For children under age 10 years, ptosis repair is covered to prevent amblyopia. Visual Field testing is not required, but clear 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**
- Patient must have a functional complaint related to brow ptosis. Brow ptosis must be documented in and 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 Visual Field testing, with differential taping (eyebrow and eyebrow + eyelid) showing 30% or more improvement in total number of points seen with the eyebrow taped up. In situations where computerized Visual Field testing is not available we will accept manual Visual Field testing.
  - In situations where Visual Field testing is not possible, see section below: [When Patient is Not Capable of Visual Field Testing.](#)
- Documentation indicating the specific brow lift procedure (e.g., supra-ciliary, mid-forehead or coronal, pretrichial, direct brow lift vs browpey, or internal brow lift).

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

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

- Patient has an anophthalmic condition; **and**
- Patient 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**
- Patient 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) Lid retraction surgery 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 patient complaints 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) (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 they sleep 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
  - GPC (Giant Papillary Conjunctivitis) that is not related to FES
  - Ptosis of the lid(s)
  - Superior Limbic Keratoconjunctivitis (SLK)

**When Patient is Not Capable of Visual Field Testing**

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

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

## **Coverage Limitations and Exclusions**

Some states require benefit coverage for services that Oxford considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Please refer to member specific benefit plan documents.

### ***Cosmetic Procedures are Excluded from Coverage***

- 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.
- Any procedure that does not meet the reconstructive criteria above in the [Indications for Coverage](#) section.
- Browpexy/internal brow lift is not designed to improve function. It is considered a Cosmetic Procedure and is not a covered service.

## **DEFINITIONS**

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

**Floppy Eyelid Syndrome (FES):** FES is characterized by significant upper eyelid laxity and chronic papillary conjunctivitis in upper palpebral conjunctiva that is poorly responsive 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/Physical Impairment:** A physical/functional 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:** 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).

**Reliability (Visual Fields):** Fixation loss is less than or equal to 33%.

## **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 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 may apply.

CPT Code	Description
<b>Blepharoplasty (Lower Eyelid)</b>	
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
<b>Blepharoplasty (Upper Eyelid)</b>	
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
<b>Brow Ptosis Repair</b>	
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

CPT Code	Description
<b>Upper Eyelid Blepharoptosis Repair</b>	
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
<b>Lid Retraction</b>	
67911	Correction of lid retraction
<b>Ectropion</b>	
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)
<b>Entropion</b>	
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)
<b>Canthus Repair and Lid Repair</b>	
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
<b>Floppy Eyelid Syndrome</b>	
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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## REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare Coverage Determination Guideline (CDG) that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee. [CDG.002.14]

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#### POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
04/01/2018	<ul style="list-style-type: none"><li>Updated supporting information; replaced reference to "MCG™ Care Guidelines, 21<sup>st</sup> edition, 2017" with "MCG™ Care Guidelines, 22<sup>nd</sup> edition, 2018"</li><li>Archived previous policy version SURGERY 018.27 T2</li></ul>