MASSACHUSETTS

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Medical Policy

Blepharoplasty, Blepharoptosis Repair and Brow Ptosis Repair

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Policy Number: 740

BCBSA Reference Number: N/A
NCD/LCD: Local Coverage Determination (LCD): Blepharoplasty, Blepharoptosis and Brow Lift (L34528)

Related Policies

Plastic Surgery, #068

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Children
Upper eyelid blepharoplasty or blepharoptosis repair is considered **MEDICALLY NECESSARY** when **BOTH** of the following criteria are met:
1. Individual is less than or equal to 9 years of age; **AND**
2. Intervention is intended to relieve obstruction of central vision which, in the judgment of the treating physician, is severe enough to produce occlusion amblyopia.

Note: Children older than 9 are not at risk for occlusion amblyopia.

Children >9 and Adults
Upper eyelid blepharoplasty or blepharoptosis repair is considered **MEDICALLY NECESSARY** for ANY of the following conditions:
1. Difficulty tolerating a prosthesis in an anophthalmic socket; **OR**
2. Repair of a functional defect caused by trauma, tumor or surgery; **OR**
3. Periorbital sequelae of thyroid disease; **OR**
4. Nerve palsy.

Note: For cases where combined procedures (for example, blepharoplasty and brow lift) are requested, the individual must meet the criteria for each procedure.

Blepharoplasty
Unilateral or bilateral **upper eyelid** blepharoplasty is considered **MEDICALLY NECESSARY** to relieve obstruction of central vision when **ALL** of the following criteria are met:

1. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin; **AND**
2. There is either redundant skin overhanging the upper eyelid margin and resting on the eyelashes or significant dermatitis on the upper eyelid caused by redundant tissue, **AND**
3. Upper field must improve by at least 20 degrees with eyelid taped compared to visual field with untaped lid**, *OR*** visual field obstruction by lid or brow must limit upper field to within 30 degrees of fixation.

Blepharoptosis Repair
Blepharoptosis repair is considered **MEDICALLY NECESSARY** to relieve obstruction of central vision when **ALL** of the following criteria are met:

1. Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position; **AND**
2. Upper field must improve by at least 20 degrees with eyelid taped compared to visual field with untaped lid**, *OR*** visual field obstruction by lid or brow must limit upper field to within 30 degrees of fixation.

Brow Lift
Brow lift (i.e., repair of brow ptosis due to laxity of the forehead muscles) is considered **MEDICALLY NECESSARY** when **ALL** of the following criteria are met:

- Upper field must improve by at least 20 degrees with eyelid taped compared to visual field with untaped lid**, *OR*** visual field obstruction by lid or brow must limit upper field to within 30 degrees of fixation.

Note: Conjunctival irritation or eye disease related to ectropion, entropion, metabolic disease, trauma or other conditions may require surgical intervention using a variety of ophthalmologic procedures. These conditions are not discussed in this document. The medical necessity of the surgical correction of these problems should be determined by considering the specific underlying medical and ophthalmologic issues.

Not Medically Necessary:
Blepharoplasty, blepharoptosis repair, or brow lift for visual field defects is considered **NOT MEDICALLY NECESSARY** when the criteria noted above are not met.

Cosmetic and Not Medically Necessary:
Blepharoplasty, blepharoptosis repair, or brow lift is considered **cosmetic and NOT MEDICALLY NECESSARY** when performed to improve an individual's appearance in the absence of any signs or symptoms of functional abnormalities.

Lower lid blepharoplasty that does not meet the above conjunctival irritation criteria is considered **cosmetic and NOT MEDICALLY NECESSARY.**

Reconstructive:
Blepharoplasty, blepharoptosis repair or brow lift procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered **reconstructive** in nature.

Medicare HMO Blue[SM] and Medicare PPO Blue[SM] Members

Medical necessity criteria and coding guidance for **Medicare Advantage members living in Massachusetts** can be found through the link below.

Local Coverage Determination (LCD): Blepharoplasty, Blepharoptosis and Brow Lift (L34528)

For medical necessity criteria and coding guidance for **Medicare Advantage members living outside of Massachusetts**, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **not required**.
Medicare HMO Blue℠	Prior authorization is **required**.
Medicare PPO Blue℠	Prior authorization is **not required**.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
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
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, 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 (eg, Fasanella-Servat type)

ICD-10 Procedure Codes

ICD-10-PCS codes:	Code Description
08SN0ZZ	Reposition Right Upper Eyelid, Open Approach
08SN3ZZ	Reposition Right Upper Eyelid, Percutaneous Approach
08SNXZZ	Reposition Right Upper Eyelid, External Approach
08SP0ZZ	Reposition Left Upper Eyelid, Open Approach
08SP3ZZ	Reposition Left Upper Eyelid, Percutaneous Approach
08SPXZZ	Reposition Left Upper Eyelid, External Approach
08SQ0ZZ	Reposition Right Lower Eyelid, Open Approach
08SQ3ZZ	Reposition Right Lower Eyelid, Percutaneous Approach
08SQXZZ	Reposition Right Lower Eyelid, External Approach
08SR0ZZ	Reposition Left Lower Eyelid, Open Approach
08SR3ZZ	Reposition Left Lower Eyelid, Percutaneous Approach
08SRXZZ	Reposition Left Lower Eyelid, External Approach

Description

Blepharoplasty is a procedure to correct drooping of the upper eye lid. This surgery is performed on the anterior lamellae which consists of skin and the orbicularis oculi muscle. Multiple conditions can cause drooping of the upper eye lid such as thyroid eye disease, floppy eyelid syndrome, blepharochalasis syndrome, trauma or any other condition that can cause stretching of the upper eyelid skin.

Blepharoptosis (or ptosis) repair is a procedure to correct the downward displacement of the upper eyelid margin. This surgery is performed on the posterior lamellae which consists of conjunctiva, tarsus, Müller's muscle, and the levator muscle with its aponeurosis. Blepharoptosis can result from myogenic, involutional, neurogenic, mechanical, or developmental causes.

Brow ptosis repair is a procedure to bring a drooping eyebrow to its correct anatomical position. Brow ptosis is a natural part of aging but can also be caused by medical conditions such as Bell's palsy, muscular dystrophy and other conditions that can affect the muscles and nerves of the face.

Summary

Blepharoplasty, bleparoptosis repair and brow ptosis repair can be performed for cosmetic purposes or to correct functional impairment/vision loss. When the purpose of these surgeries is to improve appearance or for any other purpose other than the criteria outlined above, they are considered not medically necessary.

Policy History

Date	Action
5/2020	Policy updated with literature review through April 2020, no references added. Policy statements unchanged.
8/2016	Policy statement on blepharoplasty clarified. 8/19/2016
12/2015	Photograph requirements for blepharoplasty removed. 12/1/2015.
10/1/2015	New medical policy describing medically necessary and not medically necessary indications; transferred from medical policy #068, Plastic Surgery. Effective 10/1/2015.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

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