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

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 BlueSM and Medicare PPO BlueSM 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
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Commercial PPO and Indemnity</th>
<th>Medicare HMO BlueSM</th>
<th>Medicare PPO BlueSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<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 (suprachiliary, mid-forehead or coronal approach)</td>
</tr>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)</td>
</tr>
<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 (eg, Fasanella-Servat type)</td>
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ICD-10 Procedure Codes

<table>
<thead>
<tr>
<th>ICD-10-PCS codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>08SN0ZZ</td>
<td>Reposition Right Upper Eyelid, Open Approach</td>
</tr>
<tr>
<td>08SN3ZZ</td>
<td>Reposition Right Upper Eyelid, Percutaneous Approach</td>
</tr>
<tr>
<td>08SNXZZ</td>
<td>Reposition Right Upper Eyelid, External Approach</td>
</tr>
<tr>
<td>08SP0ZZ</td>
<td>Reposition Left Upper Eyelid, Open Approach</td>
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<tr>
<td>08SP3ZZ</td>
<td>Reposition Left Upper Eyelid, Percutaneous Approach</td>
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<tr>
<td>08SPXZZ</td>
<td>Reposition Left Upper Eyelid, External Approach</td>
</tr>
<tr>
<td>08SQ0ZZ</td>
<td>Reposition Right Lower Eyelid, Open Approach</td>
</tr>
<tr>
<td>08SQ3ZZ</td>
<td>Reposition Right Lower Eyelid, Percutaneous Approach</td>
</tr>
<tr>
<td>08SQXZZ</td>
<td>Reposition Right Lower Eyelid, External Approach</td>
</tr>
<tr>
<td>08SR0ZZ</td>
<td>Reposition Left Lower Eyelid, Open Approach</td>
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<td>08SR3ZZ</td>
<td>Reposition Left Lower Eyelid, Percutaneous Approach</td>
</tr>
<tr>
<td>08SRXZZ</td>
<td>Reposition Left Lower Eyelid, External Approach</td>
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</tbody>
</table>

Description
Blepharoplasty is a procedure to correct drooping of the upper eyelid. 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 eyelid 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, blepharoptosis 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

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>8/2016</td>
<td>Policy statement on blepharoplasty clarified. 8/19/2016</td>
</tr>
<tr>
<td>12/2015</td>
<td>Photograph requirements for blepharoplasty removed. 12/1/2015.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>New medical policy describing medically necessary and not medically necessary indications; transferred from medical policy #068, Plastic Surgery. Effective 10/1/2015.</td>
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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
References