



Medical Coverage Policy

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Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted

for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses blepharoplasty, blepharoptosis repair, brow lift procedures, and upper and lower eyelid retraction surgery performed for functional indications. This Coverage Policy addresses lower or upper eyelid ectropion or entropion repair for corneal and/or conjunctival injury or disease due to ectropion, entropion or trichiasis.

Coverage Policy

Coverage for blepharoplasty varies across plans. Refer to the customer's benefit plan document for coverage details.

If coverage for the specific service is available, the following conditions of coverage apply:

An UPPER eyelid reconstructive blepharoplasty (Current Procedural Terminology [CPT] code 15822, 15823) is considered medically necessary for ANY of the following indications when the associated criteria are met:

- blepharochalasis, dermatochalasis or pseudoptosis with upper visual field loss of at least 20 degrees or 30% on visual field testing that is corrected by at least 20 degrees or 30% on visual field testing when the upper lid margin is elevated by taping the eyelid **AND** preoperative frontal photographs demonstrate **BOTH** of the following:
 - light reflex in the cornea with the head upright and the individual looking straight ahead (i.e., not tilted)
 - findings consistent with visual field loss documented on visual field testing
- difficulty tolerating a prosthesis in an anophthalmic socket
- painful blepharospasm that is refractory to medical management (e.g., botulinum toxin injections)
- orbital sequelae of thyroid disease or nerve palsy (e.g., exposure keratitis)
- upper-eyelid defect caused by trauma, tumor or ablative surgery resulting in a severe physical deformity or disfigurement which is causing functional visual impairment as confirmed by preoperative frontal photographs

UPPER eyelid ptosis (blepharoptosis) repair (CPT code 67901–67908) is considered medically necessary when there is upper visual field loss of at least 20 degrees or 30% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelid, the upper eyelid margin reflex distance 1 (MRD₁) is ≤ 2.0 mm AND preoperative frontal photographs demonstrate BOTH of the following:

- light reflex in the cornea with the head upright and the individual looking straight ahead (i.e., not tilted) **OR** encroachment of the upper eyelid into the visual field which would prevent the corneal light reflex

- findings consistent with visual field loss documented on visual field testing

UPPER eyelid ptosis (blepharoptosis) repair (CPT code 67901–67908) is considered medically necessary in an infant or child less than or equal to seven years of age when there is a functional visual impairment as documented by preoperative frontal photographs which demonstrate light reflex in the cornea with the head upright and the individual looking straight ahead (i.e., not tilted) OR encroachment of the upper eyelid into the visual field which would prevent the corneal light reflex.

LOWER or UPPER eyelid ectropion or entropion repair (CPT code 67914–67924) is considered medically necessary for corneal and/or conjunctival injury or disease due to ectropion, entropion or trichiasis.

A brow lift (e.g., repair of brow ptosis for laxity of the forehead muscles) (CPT code 67900) is considered medically necessary when ALL of the following criteria are met:

- brow ptosis is causing functional visual impairment confirmed by photographs demonstrating that the eyebrow is below the supraorbital rim
- individual complains of interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through eyelashes or seeing upper eyelid skin
- upper visual field loss of at least 20 degrees or 30% on visual field testing that cannot be corrected by upper lid blepharoplasty
- findings consistent with visual field loss documented on visual field testing

A combination of ANY of the above procedures is considered medically necessary when the medical necessity criteria for each procedure are met and BOTH of the following additional criteria are met:

- photos and visual field testing demonstrate visual impairment that cannot be addressed by one procedure alone
- lateral and full-face photographs with attempts at 1) brow elevation and, 2) upward gaze (i.e., with the brow relaxed) support the request
- findings consistent with visual field loss documented on visual field testing

Surgical correction of UPPER or LOWER eyelid retraction (CPT code 67911) is considered medically necessary when there is functional impairment or failure of medical management of symptoms. Surgical correction of UPPER or LOWER eyelid retraction that is being performed for the sole purpose of improving appearance is considered cosmetic in nature and not medically necessary.

A lower eyelid reconstructive blepharoplasty (CPT code 15820, 15821) is considered medically necessary for ANY of the following indications when there is a functional visual impairment as documented by preoperative frontal photographs:

- lower eyelid edema due to a metabolic or inflammatory disorder when the edema is causing a persistent visual impairment (e.g., secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome) and is unresponsive to conservative medical management
- corneal and/or conjunctival injury or disease due to entropion or epiblepharon
- lid laxity with uncontrolled tearing and/or irritation as documented by history

Upper and/or lower eyelid blepharoplasty in the absence of a functional impairment or is being performed for the sole purpose of improving appearance is considered cosmetic in nature and not medically necessary.

General Background

Blepharoplasty is generally performed for dermatochalasis (i.e., excess of eyelid skin) and corrects bagginess, fatty protrusions, and lax hanging skin around the eyes. If the eyelid itself is drooping, this is termed blepharoptosis and is corrected with a different procedure, a ptosis repair. A blepharoplasty may be performed for functional or cosmetic reasons. Cosmetic surgery is an attempt to improve the appearance of structures or tissues that are functionally and histologically normal. The goal of functional or reconstructive surgery is to restore to normal a structure that has been altered by infection, trauma, degeneration, inflammation, developmental errors, or neoplasia. Blepharoplasty is often done in combination with other functional or cosmetic procedures (e.g., brow lift) to restore more complete function or facial expression (Kim, et al., 2022; McGrath, et al., 2012).

Prior to blepharoplasty, reconstructive eyelid surgery and/or brow lift, a preoperative evaluation, which includes a detailed medical and ocular history along with a thorough ophthalmologic examination, is generally performed. Generally, individuals are treated by ophthalmic plastic and reconstructive surgeons who specialize in diseases and problems of the eyelids, tear drain and orbit. It is recommended that patients be examined for active eye disease, dry eyes, and thyroid disease, which are contraindications to eyelid surgery. Fine examination of the lid margin for chronic blepharitis, evidence of lid retraction or laxity, and signs of associated systemic disease such as thyroid disease or other problems should be assessed prior to surgery. The excessive eye bulk that may result from these conditions will typically resolve after adequate medical treatment, obviating the need for surgical intervention. The physical examination may include a Schirmer test, tear film break-up time, visual acuity with and without correction, and visual fields testing. It is recommended that preoperative photographs be taken with the eyes in primary position (American Society of Ophthalmic Plastic and Reconstructive Surgery [ASOPRS], 2024a, 2024b, 2024c; Purewal, et al., 2005; Spinelli, 2004b; Brown, 2003; Stephenson, 1997).

Visual Field Testing

Visual field testing is used to measure the severity of eyelid and brow defects. The most significant visual field measurement associated with determining the need for blepharoplasty, blepharoptosis repair and/or brow lift is the superior visual field. The normal extent of the superior visual field is approximately 55–60 degrees at the 90-degree meridian. Impairment of the superior visual field can range from 20%, considered mild ptosis, to 64% in more severe cases where the eyelid crosses the middle of the pupil. In general, mild to moderate impairment of the visual field is of no clinical significance and requires no intervention. When obstruction of the visual field becomes severe or significant enough to interfere with the patient's ability to perform activities of daily living, surgical intervention may be warranted. In a study by Riemann et al. (2000), Goldmann manual kinetic and Humphrey automated static visual field testing were both effective in documenting ptosis-associated visual field loss. It is recommended that visual field testing demonstrates a minimum of at least 20 degrees or 30% loss of upper field vision with upper lid skin and/or upper lid margin in repose and elevated (by taping of the lid) to demonstrate potential correction by the proposed procedure or procedures (Centers for Medicaid and Medicare Services [CMS], 2019 and 2020; Riemann, et al., 2000; Meyer, et al., 1993; Meyer, et al., 1989). Visual field testing is generally not performed in infants and children less than or equal to seven years of age.

Conditions Associated with Blepharoplasty, Reconstructive Eyelid Surgery and Brow Lift

Blepharochalasis: Blepharochalasis is a rare condition that afflicts young people, usually in their teens. Redundant skin of the upper eyelid hangs down and may conceal the tarsal margin when the eye is open, impairing the visual field. It may be associated with the disease process of chronic blepharoidema and can lead to thinning of the eyelid skin and prolapse of orbital fat. Blepharoplasty, usually in combination with advancement of the levator aponeurosis (major elevator of the upper eyelid), may be indicated (Purewal, et al., 2005).

Blepharospasm: Blepharospasm is a condition in which the muscles in the eyelids and around the eyes twitch uncontrollably. There is no cure for this condition, and effective treatments are limited. Uncontrolled blepharospasm can become debilitating. Treatment can include artificial tear drops or lubricating ointment, or both. The treatment of choice for blepharospasm is an injection of botulinum toxin in the eyelids and around the eyes to paralyze them. This is a temporary treatment lasting about three to four months. If botulinum toxin is not effective, surgery can be considered. Blepharoplasty surgery involves removing the surrounding eye muscles (complete or partial myectomy) to control the blepharospasm permanently (Faucett, 2013; Patel, et al., 2005a).

Brow Ptosis (Brow Lift): Brow ptosis refers to sagging tissue of the eyebrows and/or forehead. Brow ptosis may accentuate upper eyelid skin redundancy. As the brow descends below the supraorbital rim, it pushes additional skin over the upper eyelid, thereby aggravating the functional deficits in the peripheral visual fields. Upper eyelid blepharoplasty alone may worsen the degree of brow ptosis by fixing the brow in an inferior position. Therefore, it is recommended that repositioning of the brow should be considered before the blepharoplasty is performed. An adjunct procedure, such as a lateral brow lift, may need to be added to the planned reconstructive blepharoplasty. Brow ptosis repair for laxity of the forehead muscles causing functional visual impairment is indicated when photographs show the eyebrow below the supraorbital rim, and there is documentation that visual field impairment cannot be corrected by reconstructive upper lid blepharoplasty alone, as shown by taped and standardized methods of visual field testing. Photographs are taken from front, side, and oblique views. It is recommended that the patient's brow be relaxed when assessing the eyebrow position. Complications of eyebrow lifts are rare but may include nerve damage, scarring, hematoma, or alopecia. Brow lift surgery techniques can include open or endoscopic approaches (Graham, et al., 2011; Hoenig, 2005; Spinelli, 2004c; Dailey, et al., 2003).

Dermatochalasis: Dermatochalasis refers to an excess of eyelid skin. The underlying muscle, connective tissue, and fat can also be excessive. Although dermatochalasis is most often a result of the natural aging process, the excess eyelid skin may result from specific disorders, such as thyroid eye disease, floppy eyelid syndrome, blepharochalasis syndrome, trauma, or any condition that causes stretching of the upper eyelid skin. Sometimes these changes are so severe in the upper lid that it obtrudes on the vision by hanging down over the lid margin, pushing down on the lashes against the cornea (Cahill, et al., 2011; Purewal, et al., 2005).

Ectropion: Ectropion is a turning out or sagging of the upper or lower eyelid. The condition mainly affects the lower eyelid. The sagging lower eyelid leaves the eye exposed and dry. As a result, excessive tearing is common. If the condition is not treated, crusting of the eyelid, mucous discharge and irritation of the eye may occur. A serious inflammation may result and damage the eye. Corneal dryness and irritation may lead to eye infections, corneal abrasions, or corneal ulcers. Causes include aging, scarring, a mass on the lower lid, and seventh nerve palsy (Yanoff and Cameron, 2016).

Ectropion can be diagnosed with a routine eye exam. Special tests are usually not necessary. No completely satisfactory nonsurgical approaches exist in the management of symptomatic ectropion. When the condition is mild, the patient may experience only mild irritation from

conjunctival exposure, usually associated with epiphora and perhaps a foreign body sensation from corneal drying. Artificial tears during the day and ointments at night usually improve the symptoms. Taping the lid into position, a frost suture, or a temporary tarsorrhaphy with sutures or glue may be useful. Nighttime eye shields which seal in moisture may be helpful. Some cases of ectropion caused by nerve problems can be treated temporarily if the eyelid nerves are expected to recover (Robinson, et al., 2013; Weizer, et al., 2006; Eliasoph, 2005; Tse, 2003).

Medical management may not be adequate when the lid malposition is so severe that corneal breakdown occurs. Surgical treatment depends on the underlying cause. There are six pathological elements that may be present in an ectropic eyelid including: horizontal lid laxity, medial canthal tendon laxity, punctal malposition, vertical tightness of the skin, orbicularis paretic secondary to seventh nerve palsy, and lower eyelid retractors disinsertion. One or more of these components may be present in an ectropic eyelid. Proper recognition of the underlying anatomic defect enables the surgeon to select the appropriate surgical procedure for correction. Scars can occur following trauma or the surgical removal of skin cancers. A skin graft taken from the upper eyelid, or from behind the ear can be used to repair the ectropion (Yanoff and Cameron, 2016; Tse, 2003; Robinson, et al., 2013).

Entropion: Entropion is an abnormal inward rotation of the eyelid. The relaxing of the eyelid tendons and eyelid muscles results in the eyelid turning inward. When the eyelid turns inward, the eyelashes and skin rub against the eye which can cause watering of the eyes (trichiasis), redness, irritation, or burning. Serious inflammation may lead to damage to the eye. Entropion occurs most commonly as a result of aging with the weakening of eyelid muscles. Entropion may occur after trauma and scar contraction or after surgery. The long-term use of medications such as some used for glaucoma may produce shrinkage and entropion. There are many subdivisions of entropion. The most common type is involutional entropion (Yanoff and Cameron, 2016; Gigantelli, 2013; Weizer, et al., 2006; Eliasoph, 2005; Katowitz, et al., 2003).

Patients who have entropion are typically evaluated as possible surgical candidates. Medical therapy is typically attempted prior to surgical repair. The extent of ocular findings, patient's age, and systemic comorbidities must be considered in developing a treatment plan. A slit lamp is used to examine the surface of the eyeball for tear problems or for damage from inverted eyelashes. Surgery to repair entropion is usually performed on an outpatient basis in the physician's office or in an ambulatory surgical center under local anesthesia. There are a number of surgical procedures, and each surgeon has a preferred surgical method to correct entropion (Gigantelli, 2013; Weizer, et al., 2006; Eliasoph, 2005; Katowitz, et al., 2003).

Epiblepharon: In epiblepharon, a horizontal fold of redundant pretarsal skin and orbicularis muscle extends beyond the eyelid margin and compresses the eyelashes against the globe. Generally, the condition is bilateral, prevalent in Asian populations, and commonly involves the lower lid. Some patients demonstrate the clinical findings at all times, whereas others are symptomatic only in downgaze. Although both epiblepharon and congenital entropion result from lower eyelid retractor defects, their clinical presentation and course contrast sharply with nearly 80% of children who show epiblepharon have no ocular complaints. Frequently, the condition resolves with the normal vertical growth of the facial bones. Although the majority of patients can be managed conservatively, treatment should not be delayed in symptomatic cases. A transcutaneous reattachment of the lower lid retractor anterior fibers to the skin and orbicularis is achieved by reforming the lower eyelid crease through the removal of a horizontal skin and orbicularis muscle strip and deep fixation suture closure (Gigantelli, 2013).

Ptosis (Blepharoptosis): Ptosis is an abnormally low position of the upper eyelid margin which is determined while the eye is looking in primary gaze. Blepharoplasty surgery and ptosis surgery are distinctly different. They are performed to correct anatomic defects in different upper eyelid

lamellae. Ptosis may result from masses, trauma, and congenital or acquired deformities of the levator or Müller neuromuscular complexes. Ptosis results myogenic, involutional, neurogenic, mechanical, traumatic, or developmental causes. Ptosis may be categorized by age of onset (congenital versus acquired), severity, and physiological etiology. Patients with ptosis may present with various symptoms, including visual field obstruction, headache, and fatigue. Surgery is considered in patients who are symptomatic. The goal of ptosis repair is to elevate the eyelid without causing excessive lagophthalmos or ocular exposure (Custer, 2013; Cahill, et al., 2011; Lee, et al., 2003).

Conditions that can mimic true ptosis but that are mechanical (pseudoptosis), and not an isolated intrinsic condition include: anophthalmic socket, hypertropia (elevation of the eyeball), blepharospasm or increased facial tone, enophthalmos (the affected eyeball is retrodisplaced with the upper eyelid draping over the anterior corneal surface), and severe dermatochalasis with or without associated brow ptosis (Spinelli, 2004c; Lee, et al., 2003).

The eyelid fissure is a measurement of the opening of the eyelid when the eye is in primary position looking straight ahead. It is measured in millimeters at the center of the eyelid from the bottom of the upper lid to the top of the lower lid. The normal measurement is 9–10 mm. Ptotic eyes are defined as those with eyelid fissures less than 9 mm. Quantitative data on the effect of ptosis on the superior peripheral field of vision has been studied. Margin reflex distances (MRDs) are measurements that are used. Upper eyelid MRD₁ is the distance from the upper eyelid to the corneal light reflex which approximates the center of the pupil and the visual axis. Normal MRD₁ is 4-5 mm. The unobstructed normal superior field measures approximately 50 degrees. Visual field impairment can occur when the MRD₁ is less than 4 mm. With an MRD₁ of 2 mm, the superior visual field impairment is in the range of 24–30%. This corresponds to 12–15 degrees of superior visual field loss. A MRD₁ measurement of greater than 2.5 mm is considered normal. Lower eyelid MRD₂ is the distance from the corneal light reflex to the lower lid. A measurement of > 5 mm represents a lower eyelid that is too low and can be caused by entropion or ectropion. A patient can have a ptotic upper eyelid and a normal eyelid fissure if the lower eyelid position is abnormally low. Levator function is a measurement of how well the levator muscle works. Normal function is greater than 11 mm. A poor levator function is ≤ 4 mm (Cohen, 2020; Custer, 2013; Edmonson, et al., 2005). An upper eyelid MRD₁ measurement of ≤ 2.0 mm is considered to be associated with significant visual impairment. Several studies show visual field impairment from ptosis is consistently present when the mid-pupil to upper eyelid distance is ≤ 2.0 mm. This is generally accepted as functional ptosis (Small, et al., 2004; Myer, et al., 1993).

It is recommended that before ptosis surgery is considered, photographic documentation of the patient while looking in primary gaze, down-gaze, and side views be required. Visual fields may be performed on each ptotic eyelid with the eyelids in their natural position and again with the eyelids taped up to simulate postsurgical response. It is recommended that the patient be examined for pupil abnormalities and motility problems prior to surgery. The Schirmer test and slit lamp examination are performed to rule out dry eye (Custer, 2013; Edmonson, et al., 2005; Spinelli, 2004c).

The most common complications of ptosis surgery are a part of the inherent inaccuracy of the procedure which involves undercorrections and overcorrections. Depending on the case series, the rate of undercorrections and overcorrections varies from 5–35%. Massaging the eyelid downward may resolve or reduce overcorrection. It is recommended that reoperating on patients with overcorrections be completed within two weeks of the original surgery, after edema has resolved, and before scarring has taken place. True complications of ptosis surgery can include lagophthalmos, exposure keratitis, lid lag, corneal ulceration, and visual loss. Patients who have congenital ptosis, postoperative lagophthalmos, or acquired myopathies require continued

evaluation after surgery to monitor for possible ocular exposure, or the development of associated ophthalmic conditions (Custer, 2008; Edmonson, et al., 2005).

Thyroid Disease: Symptoms that are associated with thyroid disease may include unilateral or bilateral upper-eyelid retraction and proptosis (i.e., protruding eye). Most often, medical treatment for the thyroid pathology will resolve these deformities, but occasionally, reconstructive blepharoplasty may be necessary to prevent corneal exposure and erosion (Anderson, et al., 2003).

Professional Societies/Organizations

American Society of Plastic Surgeons (ASPS): The ASPS states that when there is visual field impairment blepharoplasty procedures are considered to be reconstructive. Blepharoplasty is considered reconstructive by the ASPS when it is performed to correct visual impairment caused by ptosis, blepharochalasis; repair congenital abnormalities or defects caused by trauma or tumor-ablative surgery. If the patient is experiencing visual field impairment, formal visual field testing by an Optometrist or Ophthalmologist is recommended. Photographs are usually taken to document the preoperative condition and aid the surgeon in planning surgery. Additional photographs may include upward and downward gaze as well as oblique views. It may be necessary for patients with a history of dry eye to undergo a Schirmer's test. Ptosis of the upper eyelid is determined by measuring the palpebral fissure width and margin reflex distance. Levator excursion is also assessed. The forehead and eyebrow should be evaluated for brow ptosis. The ASPS states that when blepharoplasty is performed to improve a patient's appearance, in the absence of any signs and/or symptoms of functional abnormalities, the procedure is considered cosmetic.

American Academy of Ophthalmology (AAO): In December 2011, the AAO published an update to the 1995 Ophthalmic Technology Assessment (OTA) for Functional Indications for Upper and Lower Eyelid Blepharoplasty. The 2011 OTA evaluates the Functional Indications for Blepharoplasty and Blepharoptosis Repair by assessing functional preoperative impairment and surgical outcomes. Functional surgical indications currently in use include impaired visual acuity, decreased peripheral vision, a compensatory chin-up backward head tilt, difficulty reading, dermatitis, eye strain and fatigue, and difficulty wearing a prosthesis in an anophthalmic socket. The literature search included studies up to July 2008. A total of 13 case series studies reported the functional effects or treatment results of simulated ptosis; several types of blepharoptosis repair, including conjunctiva-Müller's muscle resection, frontalis suspension, and external levator resection; and upper eyelid blepharoplasty. The inclusion criteria were that the publication was an original report that it was relevant to surgical treatment of ptosis or upper eyelid dermatochalasis, that it reported a primary outcome of functional improvement, and that it had a follow-up period of at least six weeks (if a surgical series). The AAO reported that the repair of blepharoptosis and upper eyelid dermatochalasis provides significant improvement in vision, peripheral vision, and quality of life activities. The studies used different perimetric techniques. Despite these testing variations, the results show similar relationships between ptosis and superior visual field loss. The unobstructed normal superior field measures approximately 50 degrees. Visual field impairment can occur when the MRD1 is less than 4 mm. With an MRD1 of 2 mm, the superior visual field impairment is in the range of 24–30%. This corresponds to 12-15 degrees of superior visual field loss. Preoperative indicators of improvement include margin reflex distance 1 (MRD1) of 2 mm or less, superior visual field loss of at least 12 degrees or 24%, down-gaze ptosis impairing reading and other close-work activities, a chin-up backward head tilt due to visual axis obscuration, symptoms of discomfort or eye strain due to droopy lids, central visual interference due to upper eyelid position, and patient self-reported functional impairment (Cahill, et al., 2011).

The AAO reported that the literature supports the following guidelines for indicating when surgical intervention is expected to provide functionally significant improvement. Ptosis and upper eyelid

blepharoplasty surgery were found to be functionally beneficial for each of these quantitative findings:

- MRD1 of ≤ 2 mm measured in primary gaze
- superior visual field loss of 12 degrees or 24%
- down-gaze ptosis impairing reading documented by MRD1 of ≤ 2 mm measured in down gaze

Ptosis and upper eyelid blepharoplasty were also found to be functionally beneficial for the following qualitative findings:

- self-reported functional impairment from upper eyelid droop
- chin-up backward head tilt induced by visual field impairment caused by lids
- interference with occupational duties and safety resulting from visual impairment caused by the upper lids
- symptoms of discomfort, eye strain, or visual interference due to the upper eyelid position

The reviewed literature did not provide strong data on the following functional indications for ptosis and blepharoplasty surgery:

- dermatitis
- difficulty wearing a prosthesis in an anophthalmic socket
- temporal visual field impairment preventing a driver from meeting licensing standards

Medicare Coverage Determinations

	Contractor	Determination Name/Number	Revision Effective Date
NCD		No National Coverage Determination found	
LCD	CGS	Blepharoplasty (L33944)	11/02/2023
LCD	Noridian	Blepharoplasty, Eyelid Surgery, and Brow Lift (L34194)	10/01/2019
LCD	Palmetto	BLEPHAROPLASTY, Eyelid Surgery, and Brow Lift (L34411)	5/20/2021
LCD	Wisconsin Physicians	Blepharoplasty, Blepharoptosis and Brow Lift (L34528)	12/28/2023
LCD	Novitas	Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (L35004)	3/21/2021
LCD	Noridian	Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286)	10/01/2019

Note: Please review the current Medicare Policy for the most up-to-date information. (NCD = National Coverage Determination; LCD = Local Coverage Determination)

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Upper Eyelid Reconstructive Blepharoplasty

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid

Upper Eyelid Ptosis

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
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)

LOWER or UPPER Eyelid Ectropion or Entropion Repair

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, 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 (eg, tarsal strip or capsulopalpebral fascia repairs operation)

Brow Lift

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
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67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
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UPPER or LOWER Eyelid Retraction

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
67911	Correction of lid retraction

Lower Eyelid Reconstructive Blepharoplasty

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad

***Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.**

References

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Revision Details

Type of Revision	Summary of Changes	Date
Annual review	<ul style="list-style-type: none"> No policy statement changes. 	4/15/2024

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