Blepharoplasty and Repair of Blepharoptosis

Policy Number: MM.06.004
Original Effective Date: 11/13/2001
Line(s) of Business: HMO; PPO; QUEST
Current Effective Date: 03/22/2013
Section: Surgery
Place(s) of Service: Outpatient

I. Description

Blepharoplasty is a surgical procedure performed on the upper or lower eyelids to excise skin, muscle and fat. It can be cosmetic or functional. Reconstructive or functional blepharoplasty is most commonly performed to correct diminished visual fields caused by the weight of excess tissue of the upper eyelid, called ptosis. Reconstructive blepharoplasty is also performed to treat eyelid lesions or alterations resulting from inflammatory processes such as Graves’ disease, blepharochalasis and floppy eyelid syndrome. Trauma to the eyelid and/or orbit may also be indications for blepharoplasty.

II. Criteria/Guidelines

A. Blepharoplasty and repair of blepharoptosis are covered (subject to Limitations/Exclusions and Administrative Guidelines) when submitted documentation supports that surgery is medically necessary and will be performed for reconstructive/functional purposes for any of the following indications:

1. Correction of visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis
2. Correction of symptomatic redundant skin weighing down on the upper lashes
3. Correction of chronic symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin
4. Prosthesis difficulties in an anophthalmia socket
5. Correction of lid retraction when the patient is unable to close the eyelids fully, leading to dryness of the eye or corneal exposure
6. Correction of lower eyelid blepharoptosis in the presence of massive lower eyelid edema secondary to systemic corticosteroid therapy, myxedema, Graves disease, nephrotic syndrome or a number of other metabolic or inflammatory disorders. The excessive eyelid
bulk, even after satisfactory treatment of the underlying systemic disease, may preclude proper positioning of eyeglasses.

7. Correction of lower eyelid blepharoptosis may also be required in cases of epiblepharon or entropion in which an extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea causing corneal irritation or erosion.

B. Visual fields demonstrate a minimum 12 degree or 30 percent loss of upper field of vision with upper lid skin and/or upper lid margin in repose and elevated (by taping the lid) to demonstrate potential correction by the proposed procedure or procedures. Visual fields are not required when blepharoplasty is for the following conditions:

1. Toxic diffuse goiter
2. Entropian and trichiasis of eyelid
3. Congenital deformities of eyelid
4. Artificial eye

C. Photographs must demonstrate one or more of the following conditions:

1. The upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.
2. The upper eyelid skin rests on the eyelashes.
3. The upper eyelid indicates the presence of dermatitis.
4. The upper eyelid position contributes to difficulty tolerating prosthesis in an anophthalmia socket.

III. Limitations/Exclusions

A. Use of this procedure for any other conditions than those listed above is not covered because it is not known to be effective in improving health outcomes.

B. Payment will not be made for ptosis repairs performed for cosmetic reasons.

IV. Administrative Guidelines

A. Precertification is required. To precertify, please complete HMSA's Precertification Request and mail or fax the form as indicated along with the following documentation:

1. Results of the visual field tests
2. Patient complaints of interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin or chronic blepharitis.
3. Photographs demonstrating one or more of the following conditions:
   a. The upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.
   b. The upper eyelid skin rests on the eyelashes.
   c. The upper eyelid indicates the presence of dermatitis.
   d. The upper eyelid position contributes to difficulty tolerating prosthesis in an anophthalmia socket.
B. Applicable codes:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid;</td>
</tr>
<tr>
<td>15821</td>
<td>with extensive herniated fat pad</td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid;</td>
</tr>
<tr>
<td>15823</td>
<td>with excessive skin weighing down lid</td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)</td>
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<tr>
<td>67902</td>
<td>frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
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<tr>
<td>67903</td>
<td>(tarso) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>(tarso) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>superior rectus technique with fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67908</td>
<td>conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)</td>
</tr>
<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
</tr>
</tbody>
</table>

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References


3. Palmetto GBA, Medicare Part B. LCD for blepharoplasty, blepharoptosis and brow lift (L28239). Revision effective date 02/14/2013.