Blepharoplasty, Blepharoptosis Repair and Brow Lift

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Related Medicare Advantage Medical/Pharmacy Coverage Policies

None

Related Documents

Please refer to CMS website for the most current applicable National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA)/CMS Online Manual System/Transmittals.
**Description**

**Blepharoplasty** is a general term for cosmetic or reconstructive plastic surgery on the eyelids involving the upper or lower lid and their medial and lateral margins. It may also involve canthoplasty (plastic surgery of the medial and/or lateral canthus [the angle formed by the meeting of the upper and lower eyelids at either side of the eye]). Excess fatty tissue, muscle and skin are removed from the upper and/or lower eyelids during the blepharoplasty procedure.
Blepharoptosis, or ptosis, describes drooping or abnormal relaxation of one or both upper eyelids. It may be due to aging, birth defect, disease or injury. It is usually caused by a weakness of the levator muscle (muscle that raises the eyelid), laxity of the eyelid skin that occurs with aging or damage to the nerves that send messages to the levator muscle. A blepharoptosis repair is a procedure to correct upper eyelid ptosis. Techniques include levator advancement or frontalis suspension. Severe ptosis may cause visual disturbances impairing peripheral and forward vision. Dermatochalasis (excessive and lax eyelid skin) may occur simultaneously with ptosis.

Brow ptosis is a condition in which the eyebrow sags or droops. Significant overhang beyond the eyelashes can interfere with vision function or can appear unsightly. It usually occurs bilaterally (both sides) but may be unilateral (one-sided). Causes include aging, thinning tissue on the forehead, paralysis of facial nerves (facial palsy), trauma or disease. Brow ptosis repair is a surgical procedure that raises the brow by removing excess skin and/or tightening lax forehead muscles. This procedure may be referred to as a brow lift or browpexy, depending on the type of surgical technique used.

Procedures may be performed to improve abnormal function related to significant visual field loss, or to reconstruct a deformity. Occasionally these procedures are requested to improve appearance without a functional impairment.

**Coverage Determination**

iCare follows the CMS requirement that only allows coverage and payment for services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member except as specifically allowed by Medicare.

In interpreting or supplementing the criteria above and in order to determine medical necessity consistently, iCare may consider the following criteria:

**Blepharoplasty, Blepharoptosis Repair, Brow Lift, Entropion and Ectropion Repair**

Functional blepharoplasty, blepharoptosis repair, brow lift, entropion and ectropion repair procedures will be considered medically reasonable and necessary when the following requirements are met:

- Goal of surgery is to restore function and normalcy to a body part that has been altered by disease or trauma (eg, degeneration, developmental errors, infection, inflammation, neoplasia); OR

- Interference with visual field, near or far visual impairment, or difficulty reading due to any of the following:
  - Blepharochalasis
  - Blepharoptosis
Brow ptosis causing malposition of the upper eyelid and demonstrating a MRD1 (Margin reflex distance) of 2 mm or less

Dermatochalasis

Looking through the eyelashes or seeing the upper eyelid skin

Pseudoptosis

Visual impairment secondary to redundant skin weighing down on upper lashes resulting in eye strain, headache, and loss of vision

Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin refractive to conservative measures (eg, antibiotics, education regarding hygiene, etc.); OR

• Visual field testing demonstrates a 12-to-15-degree superior field loss or 24% to 30% superior visual field impairment; OR

• Presence of prosthesis difficulties in an anophthalmic socket; OR

• Presence of ectropion (laxity and turning outward of the lower eyelid) resulting in corneal and conjunctival exposure, eye irritation, inflammation and excessive tearing; OR

• Presence of entropion (inward rotation of the eyelid margin) causing eyelashes to contact the cornea resulting in discomfort, redness, tearing, and foreign body sensation; OR

• Lower eyelid edema, tumor or mass causing signs and symptoms of eyelid ectropion

**Lower Eyelid Blepharoplasty**

Lower eyelid blepharoplasty to relieve excessive lower lid bulk will be considered medically reasonable and necessary when the following requirements are met:

• Individual requires continuous wear prescription eyeglasses if:

  • Proper positioning of prescription eyeglasses is precluded AND is secondary to conditions such as:

    ▪ Chronic systemic corticosteroid therapy; OR
    ▪ Dermatomyositis; OR
    ▪ Graves’ disease; OR
    ▪ Myxedema; OR
    ▪ Nephrotic syndrome; OR
    ▪ Polymyositis; OR
Scleroderma; OR
Sjogren’s syndrome; OR
Systemic lupus erythematosus

**Canthoplasty**

Canthoplasty will be considered medically reasonable and necessary when any of the following requirements are met:

- Performed in conjunction with a medically necessary ectropion or entropion repair
- Performed to restore the function of the eyelid when ectropion, entropion, or lagophthalmos are causing signs or symptoms of corneal or conjunctival exposure
- Required to restore the function of the eyelid after surgery for skin cancer

**Eyelid Repair**

Reduction of overcorrection of ptosis following a blepharoplasty or blepharoptosis repair will be considered medically reasonable and necessary.

Correction of eyelid retraction will be considered medically reasonable and necessary when both of the following requirements are met:

- Due to muscular or neurological deficits caused by a congenital defect, disease (eg, cancer, thyroid disease), surgery or trauma; AND
- Functional visual impairment due to epiphora (excessive tearing/eye watering) and/or ocular pain

The use of the criteria in this Medicare Advantage Medical Coverage Policy provides clinical benefits highly likely to outweigh any clinical harms. Services that do not meet the criteria above are not medically necessary and thus do not provide a clinical benefit. Medically unnecessary services carry risks of adverse outcomes and may interfere with the pursuit of other treatments which have demonstrated efficacy.

**Coverage Limitations**

Cosmetic surgery or expenses incurred in connection with such surgery is not a covered Medicare benefit. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (ie, as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. These treatments and services fall within the Medicare program’s statutory exclusion that prohibits payment for items and services that have not been
demonstrated to be reasonable and necessary for the diagnosis and treatment of illness or injury (§1862(a)(1) of the Act).

Note: This exclusion does not apply to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.22

**Coding Information**

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

<table>
<thead>
<tr>
<th>CPT® Code(s)</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid;</td>
<td></td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive herniated fat pad</td>
<td></td>
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<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid;</td>
<td></td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
<td></td>
</tr>
<tr>
<td>21280</td>
<td>Medial Canthopexy</td>
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</tr>
<tr>
<td>21282</td>
<td>Lateral Canthopexy</td>
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<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
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<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)</td>
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<tr>
<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
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<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach</td>
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<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
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<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
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<td>67908</td>
<td>Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)</td>
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<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
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<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
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<tr>
<td>67914</td>
<td>Repair of ectropion; suture</td>
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<tr>
<td>67915</td>
<td>Repair of ectropion; thermocauterization</td>
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<td>67916</td>
<td>Repair of ectropion; excision tarsal wedge</td>
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<tr>
<td>Code</td>
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<tr>
<td>67917</td>
<td>Repair of ectropion; extensive (e.g., tarsal strip operations)</td>
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<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
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<tr>
<td>67922</td>
<td>Repair of entropion; thermocauterization</td>
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<tr>
<td>67923</td>
<td>Repair of entropion; excision tarsal wedge</td>
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<td>67924</td>
<td>Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)</td>
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<tr>
<td>67950</td>
<td>Canthoplasty (reconstruction of canthus)</td>
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<tr>
<td>67961</td>
<td>Excision and repair of eyelid, involving lid margin, tarsus, conjunctive, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement, up to ¼ of lid margin</td>
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<tr>
<td>67966</td>
<td>Excision and repair of eyelid, involving lid margin, tarsus, conjunctive, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement, over ¼ of lid margin</td>
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CPT® Category III Code(s) | Description | Comments |
---|---|---|
No code(s) identified

HCPCS Code(s) | Description | Comments |
---|---|---|
No code(s) identified

References


Change Summary

- 01/01/2024 New Policy.
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