Clinical Policy Title: Blepharoplasty

Clinical Policy Number: 10.03.01

Effective Date: July 1, 2013
Initial Review Date: June 19, 2013
Most Recent Review Date: May 1, 2018
Next Review Date: May 2019

Related policies:
None.

ABOUT THIS POLICY: Prestige Health Choice has developed clinical policies to assist with making coverage determinations. Prestige Health Choice’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Prestige Health Choice when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Prestige Health Choice’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Prestige Health Choice’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Prestige Health Choice will update its clinical policies as necessary. Prestige Health Choice’s clinical policies are not guarantees of payment.

Coverage policy

Prestige Health Choice considers the use of blepharoplasty to be clinically proven and, therefore, medically necessary when the following criteria are met, as per the Center for Medicare & Medicaid Services [CMS] local coverage determinations and medical policy article A52847 listed below:

<table>
<thead>
<tr>
<th>✔</th>
<th>Criteria for medical necessity</th>
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<tbody>
<tr>
<td></td>
<td><strong>Upper eyelid reconstructive blepharoplasty</strong> (current procedural terminology [CPT] codes 15822, 15823) is considered medically necessary for correction of functional visual impairment due to any of the following indications:</td>
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<tr>
<td></td>
<td>o Dermatochalasis, blepharochalasis, or blepharoptosis with visual field impairment, whether in primary gaze or down-gaze reading position.</td>
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<td></td>
<td>o Ptosis or prosthesis difficulties in an anophthalmic socket.</td>
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<td>o Epiphora (i.e., excessive tearing) due to ectropion and/or punctual eversion.</td>
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<td>o Painful blepharospasm when debilitating and other treatments have failed or</td>
</tr>
</tbody>
</table>
Criteria for medical necessity

- are contraindicated (i.e., an injection of botulinum toxin A); an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary.
  - 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.
  - Congenital ptosis when needed to allow proper visual development and prevent amblyopia in infants and children with moderate to severe ptosis interfering with vision. Surgery is considered cosmetic if performed for mild ptosis that is only of cosmetic concern. Photographs must be available for review to document that the skin or upper eyelid margin obstructs a portion of the pupil.

- **Lower lid blepharoplasty** (CPT codes 15820 and 15821) is considered medically necessary for correction of functional visual impairment due to any of the following indications:
  - Horizontal lower eyelid laxity of medial and lateral canthus resulting in dacryostenosis and infection.
  - Significant lower eyelid edema.
  - When glasses rest upon the lower eyelid tissues and cause lower eyelid ectropion as a result of the weight of the glasses and weight of the tissue.

- **Combination of blepharoplasty, blepharoptosis repair, and/or brow lift** is considered medically necessary when the medical necessity criteria for each procedure are met and both of the following additional criteria are met:
  - Visual field testing demonstrates 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.

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Required documentation
(Must meet requirements from sections A, B, and C below)

<table>
<thead>
<tr>
<th>A. Patient signs and symptoms which justify blepharoplasty may include any of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Interference with vision or visual field, related to activities such as, difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue.</td>
</tr>
<tr>
<td>o Chronic eyelid dermatitis due to redundant skin.</td>
</tr>
<tr>
<td>o Difficulty wearing prosthesis.</td>
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</tbody>
</table>
| ✓ | **Required documentation**  
(Must meet requirements from sections A, B, and C below) |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>o</td>
<td>Chronic blepharitis.</td>
</tr>
</tbody>
</table>
| B. | Photographs and medical documentation of indications causing malpositioning of the eyelid(s). Also may include:  
| o | Margin reflex distance (MRD) of ≤ 2.5 mm; the upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.  
| o | A palpebral fissure height on down-gaze of ≤ 1 mm. The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated).  
| o | The presence of Herring's effect meeting one of the above two criteria. |
| C. | Visual fields testing must do all of the following:  
| o | Demonstrate a minimum 12° or 30 percent loss of upper field of 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.  
| o | Meet accepted quality standards, whether they are performed by Goldmann technique or by use of a standardized automated technique.  
| o | Visual field testing is not necessary for:  
| 1. | Patients with an anophtholmic socket who is experiencing ptosis or difficulty with their prosthesis.  
| 2. | Patients who are not capable of performing the testing, for example:  
| a. | Child 12 years old or under.  
| b. | Patient with mental retardation or some other severe neurologic disease.  
| c. | Coverage will be determined on the basis of clinical notes documenting eyelid abnormality, MRD-1 of ≤ 2.5 mm and photographs confirming the eyelid abnormality. |

**Limitations:**

Coverage determinations are subject to benefit limitations and exclusions as delineated by the state Medicaid authority. The Florida Medicaid website may be accessed at http://ahca.myflorida.com/Medicaid/.

All other uses of blepharoplasty are not medically necessary. Prestige Health Choice considers blepharoplasty, performed solely to enhance a patient’s appearance, in the absence of any signs or symptoms of functional abnormalities, to be not medically necessary for individuals who do not meet the
Above criteria.

**Alternative covered services:**

Evaluation by network primary care physicians and eye care professionals.

**Background**

Blepharoplasty is a procedure that reconstructs eyelid deformities and improves abnormal function and/or enhances appearance of the eyelids. It involves the excision of excess skin, muscle or fat from the upper and lower eyelids and may include rearrangement of the structures with the eyelids and/or tissues of the cheek, forehead and nasal areas using local or distant tissue grafts to reconstruct the normal structure of the eyelid. Advances in minimally invasive techniques, including laser-assisted applications, may allow for greater patient comfort, fewer complications and more rapid recovery (American Society of Plastic Surgeons [ASPS], 2007a). The annual number of blepharoplasties (for functional reasons) in the U.S. tripled from 2001 to 2011 (now 136,000 a year), while the cost quadrupled to $80 million a year (Prendiville, 2014).

Blepharoplasty is considered restorative and, therefore, medically necessary when it is performed to restore significant function to the eyelid that has been altered by trauma, infection, inflammation, degeneration (e.g., from aging), neoplasia, or developmental defects. Cosmetic blepharoplasty is performed to improve a patient’s appearance in the absence of any signs and/or symptoms of functional abnormalities and is not considered medically necessary (ASPS, 2007a).

Patients who may require restorative blepharoplasty present with a variety of symptoms or combination of symptoms, including edema, visual field defects, hypertrophy of the obicularis oculi, conjunctival inflammation, keratitis, malar festoons, blepharospasm, blepharochalasis, dermatochalasis, lagophthalmos, protrusion of orbital fat, eyelid ptosis, and eyebrow ptosis. To assess for ophthalmic and periocular disease, surgeons look for current illnesses, dry eye, allergies, history of eyelid swelling, thyroid disease, heart failure, and bleeding tendencies in the medical history.

Contraindications to blepharoplasty include:

- Underlying conditions, such as Graves’ disease, that may be related to the development of conditions that cause visual field loss, as the excessive eye bulk that may result from these conditions will typically resolve after adequate medical treatment, obviating the need for surgical intervention.
- Untreated thyroid disease.
- Conditions associated with dry eye syndrome (e.g., collagen vascular disorders, lupus, rheumatoid arthritis, or Sjögren’s syndrome).
- Active eye disease.

Surgical planning involves several factors, including whether upper or lower eyelids or both will be
surgically treated and the extent of surgical involvement, which technique(s) to use, and any adjunctive procedures to be performed to restore more complete function or facial expression and for aesthetic improvement. Adjunctive procedures include brow ptosis repair (internal trans-blepharoplasty, direct, coronal, or endoscopic), ptosis repair, lacrimal gland suspension, eyelid lengthening and lower eyelid tightening, or lateral canthopexy (Oestreicher, 2012).

Documentation of medical necessity should include indications for reconstructive blepharoplasty, the severity of the symptoms of eyelid deformities and/or the impact on health-related quality of life. If the patient is experiencing visual impairment, formal visual field testing by an optometrist or ophthalmologist may be needed. A complete eye exam may also be appropriate in certain cases. Other diagnostic studies, as clinically indicated, should be performed and noted, such as Schirmer’s test (tearing or dry eye test), CBC/BMP, bleeding and clotting studies, and cardiac evaluation. Preoperative photographs may be taken to meet the requirements of both the insurers and surgeons. Additional photographs may include upward and downward gaze as well as oblique views (ASPS, 2007a).

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 is the superior visual field. The normal extent of the superior visual field is approximately 55° to 60° at the 90° meridian. Impairment of the superior visual field can range from 20 percent, considered mild ptosis, to 64 percent 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. Generally accepted criteria for clinically significant visual field impairment are a minimum of at least 20° or 30 percent 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 (Oestreicher, 2012, ASPS 2007a, ASPS 2007b).

While blepharoplasty is a widely practiced surgical procedure, the potential for complications exists due to the complex structure and function of the eyelids. Complications range from minor to serious and may be perceived differently between patient and surgeon. These include superficial ecchymosis and hematoma, wound dehiscence, scar abnormalities, upper eyelid overcorrection, lower eyelid overcorrection and retraction, asymmetry, ptosis, epiphora and ocular discomfort, diplopia, ocular injury, orbital hemorrhage and vision loss, pigmentary abnormalities, and CO₂ laser resurfacing. Most complications can be avoided or mitigated through appropriate patient selection, pre-surgical planning and choice of surgical technique, and most can be treated effectively (Oestreicher, 2012).

**Searches**

Prestige Health Choice searched PubMed and the following databases:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
• The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on March 14, 2018. Search terms were: "blepharoplasty" [MeSH].

We included:

• **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.

• **Guidelines based on systematic reviews**.

• **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

The American Society of Plastic Surgeons (ASPS, 2007) and the American Academy of Ophthalmology (Cahill, 2011) have produced guidelines for blepharoplasty. Evaluating the efficacy of the procedure is difficult, as the medical literature contains very few randomized controlled studies (RCTs) on the technique (Chang, 2012).

While the procedure rarely results in major damage to the patient, a survey of 720 American and British plastic surgeons estimated that permanent and temporary vision loss risk were 1 in 30,000 and 1 in 50,000 procedures, respectively. Hypertension was the greatest risk factor, while retrobulbar hemorrhage was the main cause of blindness (Mejia, 2011).

A study of 200 patients who underwent blepharoplasty found 32 complications in 19 patients, the equivalent of 9.5 percent (Patrocinio, 2011). One systematic review compared outcomes of four materials used in 53 blepharoptosis procedures; it found a range of 87 to 99 percent, 0.6 to 1.9 percent for suture infections, and 5 to 25 percent for complications (Pacella, 2016).

Side effects from blepharoplasty can be a concern, particularly anesthetic use. One study found that during the procedure, 2 percent lidocaine injections using a sharp needle had greater average pain than when using a blunt needle — 5.48 to 4.64 on the visual analog scale of 0 to 10. Bruises or hematomas were found at 11 of 44 sharp needle sites, compared to 0 of 44 in blunt needle sites (Yu, 2017). Lidocaine with epinephrine used in anesthesia for blepharoplasty had significantly less pain during anesthetizing than did prilocaine with felypressin (Pool, 2015b).

Postoperative side effects have also been addressed. A survey of 51 blepharoplasty patients reported postoperative peak levels for pain (four hours, average 2.45 pills), swelling and bruising (24 hours), and itching (three days) (Parbhu, 2011). Using a pulsed electromagnetic energy patch made no difference in post-operative pain, edema, or ecchymosis (Czyz, 2012). Among 38 patients, eyelid cooling failed to reduce
post-operative edema, erythema, hematoma of the eyelids, and pain on the day of surgery, but reduced pain one day after blepharoplasty (Pool, 2015c).

Some blepharoplasties are performed simultaneously on both eyelids. One study of 127 patients who underwent the procedure found a significant difference between marginal reflex distance from 1.62 to 3.97 mm before and after surgery, with favorable results and minimal complications (Hu, 2016). Another study of double-eyed blepharoplasty in 51 eyes of 39 patients with aponeurotic ptosis (aging eyelids) concluded 88 percent were successful (Li, 2011).

A Cochrane review of involutional entropion techniques of the lower eyelid identified one RCT with 63 subjects that found the combination of horizontal and vertical eyelid tightening with everting sutures and lateral tarsal strip was highly curative for entropion compared to vertical tightening with everting sutures alone in an elderly population (Boboridis, 2011). The authors also noted that the findings were supported by many good-quality uncontrolled studies on specific surgical procedures that did not meet criteria for inclusion.

Analyses that capture patient-centered benefits of blepharoplasty can be used to inform future economic studies. Smith et al. conducted a cross-sectional study to measure self-reported patient benefit derived from four common oculoplastic procedures using a global quality-of-life scale called the Glasgow benefit inventory (GBI) (Smith, 2012). The GBI generates a scale from -100 (maximal detriment) through zero (no change) to +100 (maximal benefit). The total GBI scores for entropion repairs (n = 66), ptosis repairs (n = 50), ectropion repairs (n = 41), and external dacryocystorhinostomies (DCR) (n = 41) were: +25.25 (95 percent CI 20.00-30.50, P < 0.001), +24.89 (95 percent CI 20.04-29.73, P < 0.001), +17.68 (95 percent CI 9.46-25.91, P < 0.001), and +32.25 (95 percent CI 21.47-43.03, P <0.001), respectively, demonstrating a statistically significant benefit from all procedures.

Policy updates:

In 2017, a total of one guideline/other and nine peer-reviewed references were added to this policy.

In 2018, one peer-reviewed publication was added to the reference list.

Summary of clinical evidence:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Yu (2017)</td>
<td><strong>Key points:</strong></td>
</tr>
<tr>
<td>Comparison of types of needles used in anesthesia</td>
<td>• RCT of 44 women undergoing bilateral upper blepharoplasty.</td>
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<td></td>
<td>• Anesthesia 2% lidocaine given with blunt needle in one eyelid, sharp needle in the other.</td>
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<tr>
<td></td>
<td>• Bruise/hematoma in 11 women with sharp needle, 0 in blunt needle group.</td>
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<tr>
<td></td>
<td>• Mean visual analog scale score higher/worse for sharp needle group (5.45 vs. 4.64).</td>
</tr>
<tr>
<td>Hu (2016)</td>
<td><strong>Key points:</strong></td>
</tr>
<tr>
<td>Simultaneous</td>
<td></td>
</tr>
<tr>
<td>Citation</td>
<td>Content, Methods, Recommendations</td>
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| blepharoplasty | • Chart review of 127 patients with simultaneous correction of blepharoptosis during double eyelid blepharoplasty using single-knot continuous non-incisional technique.  
• Simultaneous correction resulted in significant difference in marginal reflux distance of eyelid (1.62 to 3.97 mm).  
• Majority of patients showed favorable outcomes during five-year follow up. |
| Pool (2015c) | **Key points:**  
• RCT with 38 patients undergoing bilateral blepharoplasty.  
• One eyelid cooled with an ice pack, one left uncooled, evaluated up to two months.  
• No difference in pain between groups.  
• Pain lower in cooled group one day post-op, but not for any other time period. |
| Chang (2012) | **Key points:**  
• Systematic review — No prospective RCT identified.  
• Systematic review of available observational studies is needed to determine efficacy and complication rates between different involutional lid ptosis repair techniques. |
| Czyz (2012) | **Key points:**  
• Randomized, double-blind study of 57 patients with upper blepharoplasty  
• Patients randomized to a low-level pulsed electromagnetic energy field patch for wound healing vs. placebo  
• No difference in patient pain with placebo (1.6) vs. patch (1.3)  
• Insignificant difference in the two groups for edema (6% less for patch) and ecchymosis (10% less for patch); significantly less physician-graded erythema for patch group |
| Patrocino (2011) | **Key points:**  
• Retrospective study of 200 patients who underwent transcutaneous blepharoplasty  
• 19 patients had complications (9.5% rate)  
• Most complications were 12 cases of chemosis, 13 who underwent canthoplasty  
• Medical treatment performed in 12 patients, revision surgery performed in 7 patients |
| Borboridis (2011) | **Key points:**  
• Cochrane review — one RCT of 63 participants included with eight lost to follow-up.  
• Combination of horizontal and vertical lower eyelid tightening with everting sutures and lateral tarsal strip is highly curative for entropion compared to vertical tightening with everting sutures alone.  
• Authors noted that results were supported by many good-quality uncontrolled studies on specific surgical procedures, but the studies did not meet criteria for inclusion. |

**CMS policies:**

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Content</th>
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</table>
| Medicare | **Coverage indications, limitations, and/or medical necessity:**  
A. Upper eyelid blepharoplasty (CPT 15822 and 15823) procedures will be considered medically necessary when performed as functional/reconstructive surgery to correct:  
1. Visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis; or visual field impairment whether in primary gaze or down-gaze |
reading position; or a decrease in peripheral vision and/or upper field vision.
2. Symptomatic redundant skin weighing down on upper lashes.
3. Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin.
4. Ptosis or prosthesis difficulties in an anophthalmic socket.

B. Lower lid blepharoplasty (CPT 15820 and 15821) is considered medically necessary when documentation:
- Supports horizontal lower eyelid laxity of medial and lateral canthus resulting in dacyrostenosis and infection.
- Supports significant lower eyelid edema.
- Reveals that glasses rest upon the lower eyelid tissues and cause lower eyelid ectropion as a result of the weight of the glasses and weight of the tissue.
- Payment may be considered on an individual consideration basis when supportive documentation (e.g., the patient's chief complaint and operative report) is included as part of the patient's medical record to demonstrate that the procedure is medically necessary for reconstructive reasons.

C. Relief of eye symptoms associated with blepharospasm (333.81). Primary essential idiopathic blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated (i.e., an injection of botulinum toxin A), an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary.

Documentation of the following criteria (A, B, C, and D, if applicable) must be met to establish medical necessity:

A. Patient signs and symptoms that justify functional surgery may include:
1. Interference with vision or visual field, related to activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin and brow fatigue.
2. Chronic eyelid dermatitis due to redundant skin.
3. Difficulty wearing prosthesis.
4. Chronic blepharitis.

B. Photographs and medical documentation of one or more of the following:
1. Frontal photos are needed to demonstrate redundant skin on the upper eyelids.
2. Upper eyelid skin resting on the eyelashes or over eyelid margin.
3. Upper eyelid indicates the presence of dermatitis, or upper eyelid dermatitis secondary to redundant skin.
4. Dermatochalasis (ICD-9 code 374.87).
5. The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmia socket.
6. Also may include:
   a. MRD of 2.5 mm or less; 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. A palpebral fissure height on down-gaze of 1 mm or less. The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated.
   c. The presence of Herring's effect meeting one of the above two criteria. (Herring's law is one of equal innervation to both upper eyelids and is
considered in the documentation to perform bilateral ptosis in which the position of one upper eyelid has marginal criteria and the other eyelid has good supportive documentation for ptosis surgery. In these cases, the surgeon can lift the more ptotic lid with tape or instillation of phenylephrine drops into the superior fornix. If the less ptotic lid then drops downward according to Herring’s law to the point of an MRD of 2.5 mm or less or a down-gaze MRD of 1.5 or less or a palpebral fissure width on down-gaze of 1 mm or less, then the less ptotic lid would be considered for surgical correction.)

C. Visual fields testing recorded to:
   1. 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 of the lid) to demonstrate potential correction by the proposed procedure or procedures. Visually significant brow ptosis may be documented by visual field testing with the brow elevated demonstrating a difference of 12° or more or 30 percent superior visual field difference.
   2. Visual fields need to meet accepted quality standards, whether they are performed by Goldmann technique or by use of a standardized automated technique.
   3. Visual fields are not necessary for patients with an anophtholmic socket who are experiencing ptosis of difficulty with their prosthesis.

D. If a combination of a blepharoplasty and another repair (e.g., ptosis repair or brow lift) are planned, both must be individually documented.

Limitations:
   1. Blepharoplasty done for cosmetic purposes, not meeting the criteria of the functional visual impairment parameters previously listed, will be denied.
   2. When the physician has determined that the patient requires a bilateral blepharoplasty, bilateral blepharoptosis repair or bilateral brow ptosis repair, it is expected that the procedures will be performed on the same date of service. Bilateral procedures performed on different dates of service require documentation in the patient’s medical record to support the medical necessity of performing these procedures on different dates of service.
   3. External ocular photography (92285) is not payable when used to support the need for blepharoplasty, blepharoptosis or brow ptosis.

References

Professional society guidelines/other:


**Peer-reviewed references:**


**CMS National Coverage Determinations (NCDs):**

No NCDs identified as of the writing of this policy.

**Local Coverage Determinations (LCDs):**


L33994 Blepharoplasty (CGS Administrators LLC). Revision effective October 1, 2015.


L34528 Blepharoplasty, Blepharoptosis and Brow Lift (Wisconsin Physicians Service Insurance Corporation).
Revision effective October 1, 2017.


**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
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<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive, herniated fat pad</td>
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<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
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<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
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<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraclival, mid-forehead or coronal approach)</td>
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<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>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>
<td></td>
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<tr>
<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
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<tr>
<td>67908</td>
<td>Repair of blepharoptosis; conjunctivo-tarso-Muller’s muscle-levator resection (e.g., Fasanella-Servat type)</td>
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<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>G24.5</td>
<td>Blepharospasm</td>
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<tr>
<td>H02.101-H02.109</td>
<td>Unspecified ectropion of eyelid</td>
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<tr>
<td>H02.111-H02.119</td>
<td>Cicatricial ectropion of eyelid</td>
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<tr>
<td>H02.121-H02.129</td>
<td>Mechanical ectropion of eyelid</td>
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<tr>
<td>H02.131-H02.139</td>
<td>Senile ectropion of eyelid</td>
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<td>H02.141-H02.149</td>
<td>Spastic ectropion of eyelid</td>
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<tr>
<td>H02.30-H02.36</td>
<td>Blepharochalasis eyelid</td>
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<tr>
<td>H02.401-H02.409</td>
<td>Unspecified ptosis of eyelid</td>
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<tr>
<td>H02.411-H02.419</td>
<td>Mechanical ptosis of eyelid</td>
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<tr>
<td>H02.421-H02.429</td>
<td>Myogenic ptosis of eyelid</td>
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<td>H02.831-H02.839</td>
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<td>H16.211-H16.219</td>
<td>Exposure keratoconjunctivitis</td>
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