Policy Number	**SUR716.004**
Policy Effective Date	**05/15/2024**
Policy End Date	**12/31/2025**

Blepharoplasty, Blepharoptosis and Brow Repair

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Related Policies (if applicable)
SUR717.001: Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0123 (IL HB 1384) Coverage for Reconstructive Services requires the following policies amended, delivered, issued, or renewed on or after January 1, 2025 (Individual and family PPO/HMO/POS; Student; Group [Small Group; Mid-Market; Large Group Fully Insured PPO/HMO/POS] or Medicaid), to provide coverage for medically necessary services that are intended to restore physical appearance on structures of the body damaged by trauma.

Coverage

This medical policy does NOT address Gender Reassignment Services (Transgender Services). This medical policy IS NOT TO BE USED for Gender Reassignment Services. Refer to SUR717.001, Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

NOTE 1: Determination of whether a proposed therapy would be considered reconstructive or cosmetic should always be interpreted in the context of the specific contract benefits language, and determination of benefit coverage for procedures considered to be cosmetic is based on

how a member's benefit contract defines cosmetic services and their eligibility for benefit coverage. In general, the presence of a functional impairment would render its treatment medically necessary and thus not subject to contractual definitions of reconstructive or cosmetic.

NOTE 2: Clinical Documentation Requirements: In order to evaluate medical necessity, the following objective information is required for requests A and B below:

1. Reliable visual field documentation that suggests active, concurrent involvement of the patient; and
2. Full face frontal photo documentation, face plane parallel to film plane and visual axis perpendicular to film plane and centered in the camera lens.

A. Blepharoplasty procedures of the upper eyelid **may be considered medically necessary** when clinical documentation requirements outlined above in **NOTE 2** are met **AND** the patient has ANY of the following:
   - Clinically significant impairment of upper/outer visual fields (<30 degrees from fixation) by excessive upper eyelid skin (dermatochalasis) with:
     - Historical medical record documentation of progressive degenerative changes of the eyelid skin inconsistent and in excess of the demographic norm of the requesting member; and
     - Accurate photo documentation of upper eyelid fold/redundant upper lid myocutaneous tissue that documents clear extension of upper lid fold over the lashes and infringing on the visual axis; or
   - Difficult prosthesis fitting in an anophthalmic socket because of drooping of the upper eyelid; or
   - Documented margin reflex distance-1 (MRD_1) less than 2 millimeter (mm), either by photo or specific medical record examination note; or
   - Severe corneal or conjunctival irritation caused by:
     - Entropion,
     - Ectropion,
     - Trichiasis caused by entropion; or
   - Periorbital sequelae of thyroid disease and/or nerve palsy; or
   - Painful symptoms related to blepharospasm, or visual symptoms of debilitating blepharospasm; or
   - Defects caused by trauma or tumor-ablative surgery.

B. Procedures to correct congenital and acquired blepharoptosis (ptosis) **may be considered medically necessary** when clinical documentation requirements outlined above in **NOTE 2** are met and the patient has **ALL** of the following:
   - Documented superior visual field constriction to less than 20 degrees that is consistent with photo documentation of the condition; and
   - Documented margin reflex distance-1 (MRD_1) less than 2 mm; and

- Documentation of the stability of any related disease processes (e.g., myasthenia gravis); and
- Accurate photo documentation of lid margin-visual axis relationship that is consistent with the visual field constriction attributed to the condition.

C. Repair procedures of the lower eyelid **may be considered medically necessary** for the following indications:
   - Facial nerve damage with inability to close the eye due to lower eyelid dysfunction; or
   - Corneal and/or conjunctival injury or disease due to ectropion, entropion, or trichiasis; or
   - Following tumor-ablative surgery; or
   - Epiphora due to ectropion and/or punctal eversion.

Blepharoplasty and ptosis procedures of the upper eyelid that do not meet the above criteria and/or is being performed primarily to improve appearance **are considered cosmetic**.

Blepharoplasty procedures of the lower eyelid **are considered cosmetic**, except as noted above in C.

Brow lift and brow ptosis repair are **considered cosmetic**.

Policy Guidelines

None.

Description

The goal of functional or reconstructive eyelid surgery is to improve abnormal function, reconstruct deformities, repair defects due to trauma or tumor-ablative surgery and in general to restore normalcy to the eyelid.

Background
Eyelid surgery may be performed for functional, reconstructive, or cosmetic purposes. The most common functional indication is a visual field defect due to excess upper eyelid tissue (dermatochalasis) that overhangs into the field of vision. However, blepharoplasty is also performed to repair ptosis, eyelid retraction, entropion, ectropion, trichiasis, or defects following tumor excision.

Brow ptosis refers to laxity of the tissue of the eyebrows and/or forehead. Brow lift procedures can raise the forehead, eyebrows and orbital areas. It is generally cosmetic and performed to correct signs of aging. However, in extreme cases, brow ptosis can be severe enough to obstruct the field of vision. Treatment of ptosis depends on age, etiology, whether one or both eyelids are involved, the severity of ptosis, the levator function, and presence of additional

ophthalmologic or neurological abnormalities. (1) Generally, treatment consists of a "watch-and-wait" policy, prosthesis, medication, or surgery.

Glossary of Terms

- Blepharochalasis – A condition separate and distinct from dermatochalasis. It is a rare disorder that typically affects the upper eyelids and is characterized by intermittent eyelid edema. It is unilateral in approximately 50% of the affected individuals and over time may result in relaxation and atrophy of the eyelid tissues.
- Blepharoplasty – A surgical intervention to reduce the age-induced alterations in the tissues of the eyelids. Upper eyelid surgery for dermatochalasis is almost always cosmetic though, infrequently, it may be functional, and correction may be necessary to treat refractory dermatochalasis and visual field obstruction from redundant upper lid tissues extending over the upper lid lashes. Typically, lower eyelid surgery is considered to be cosmetic.
- Blepharoptosis – Abnormally low positions of the upper eyelid margin, as determined while the eye in primary gaze. As with appearance related conditions, there is significant variation in the position of the upper eyelid in primary gaze. "Normal" upper eyelid position is considered to be approximately 4 millimeters (mm), plus or minus several mm. Ptosis may be either congenital or acquired.
- Blepharospasm – Muscles in the eyelids and around the eyes twitch uncontrollably.
- Brow ptosis – Sagging tissue of the eyebrows and/or forehead. Brow ptosis is caused by aging changes in the forehead muscle and skin, which leads to weakening of these tissues and sagging eyebrows. Repair of brow ptosis is performed to tighten the muscular structures supporting the eyebrow. The surgery is performed through a supra-brow incision over the affected eye. This surgery is often called brow lift surgery/repair, brow ptosis repair, brow lift, browplasty, browpexy.
- Dermatochalasis – An aging change of the eyelids related to loss of tone in the various layers underlying the skin. It is a common finding seen in elderly persons and occasionally in young adults. The changes reflect the effects of gravity, loss of elastic tissue in the skin and weakening of the connective tissues of the eyelid.
- Ectropion – Outward rotation of the lower eyelid margin and lid support. As with entropion, the condition is almost always acquired, if progressive and has a similar multifactorial causation.
- Entropion – Inward rotation of the lower eyelid margin and lid support. It is almost always acquired and progressive. The etiology is likely a combination of factors and includes an attenuation of several tissue layers that stabilize lower lid function and laxity of the margin stabilizers.
- Marginal Reflex Distance 1 (MRD_1) – Measures the number of mm from the corneal light reflex or center of the pupil to the *upper* lid margin.
- Marginal Reflex Distance 2 (MRD_2) – Measures the number of mm from the corneal light reflex or center of the pupil to the *lower* lid margin.
- Ptosis – Occurs when the eyelid droops more than is considered normal, potentially impairing vision. Drooping of the upper eyelid may be minimal (1-2 mm), moderate (3-4 mm), or severe (>4 mm), covering the pupil entirely. (1) Ptosis is usually categorized as

either “true ptosis,” an intrinsic disturbance of the eyelid structures, or as “pseudoptosis,” a lack of normal eyelid support or the presence of excess lid tissue that “hoods” the eye, restricting the upward gaze and blocking the peripheral or forward vision.

- Trichiasis – Abnormally positioned eyelashes that are directed posteriorly toward the surface of the eye, such that the lashes are touching the cornea or conjunctiva.
- Visual Field – Total area in which objects can be seen in the peripheral vision while the eye is focused on a central point.
- Visual Field Test – Measurement of all of the area a person can see while they are looking straight ahead and includes the area straight ahead as well as all peripheral vision.

Types of Visual Field Tests

- Confrontation Visual Field Exam – This is a quick and basic check of the visual field. The health care examiner sits directly in front of the individual. One eye will be covered, and the individual will be asked to stare straight ahead with the other eye. The individual will be asked to tell when he/she can see the examiner's hand.
- Tangent Screen or Goldmann Field Exam – The individual will sit about 3 feet from a screen with a target in the center. The individual will be asked to stare at the center object and let the examiner know when he/she can see an object that moves into their side vision. This exam creates a map of their entire peripheral vision.
- Automated Perimetry – The individual will sit in front of a concave dome device and stare at an object in the middle. Once he/she sees small flashes of light in their peripheral vision, the individual presses a button on the device. The responses help determine if there is a defect in their visual field.

Regulatory Status

Blepharoplasty and brow repair are surgical procedures and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

Rationale

The policy was created in 1990 and has been updated regularly with available literature reviews through the PubMed database. The most recent review is through February 21, 2023. The following is a summary of key literature.

In recent years, few studies have been published on the indications or established surgical criteria of blepharoplasty and eyelid/eyebrow ptosis repair. Historically, eyelid surgery has been described for over a century, beginning in 1818. (2)

Meta-Analysis/Literature Review

In 2011, the American Academy of Ophthalmology (AAO) published a meta-analysis by Cahill et al. (3) with the objective to evaluate the functional indications and outcomes for blepharoplasty and blepharoptosis repair by assessing functional preoperative impairment and surgical results. The authors conducted literature searches, not a systematic review, of the PubMed and

Cochrane Library databases on July 24, 2008, with no age or date restrictions, and limited to articles published in English. These searches retrieved 1147 citations; 87 studies were reviewed in full text, and 13 studies met inclusion criteria and were included in the evidence analysis. The 13 studies reported the functional effects or treatment results of simulated ptosis; several types of blepharoptosis repair, including conjunctival-Müller's muscle resection (MMCR), frontalis suspension, and external levator resection; and upper eyelid blepharoplasty.

Cahill et al. concluded that repair of blepharoptosis and upper eyelid dermatochalasis provides significant improvement in vision, peripheral vision, and quality of life activities. Preoperative indicators of improvement include margin reflex distance 1 (MRD_1) of 2 millimeters (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.

Following their 2008 meta-analysis, Moore et al. (4) released study of MMCR with skin-only blepharoplasty. Clinical data from 274 eyes that met the inclusion criteria were reviewed. MMCR was performed in 198 eyes, with concurrent blepharoplasty in 76 eyes. The MRD_1 was similar between patients undergoing MMCR alone versus those undergoing MMCR with blepharoplasty. For similar amounts of tissue resection, the postoperative change of MRD_1 was similar for patients undergoing MMCR-only surgery and MMCR with blepharoplasty. The authors concluded combining MMCR surgery with skin-only blepharoplasty does not alter eyelid height when compared with MMCR surgery alone when correcting eyelid ptosis.

Chang et al. published a systematic review in 2012. (5) The authors reviewed literature published in PubMed and Cochrane Central Register of Controlled Trials databases that yielded trials on comparison of different adult upper lid involutional ptosis repair techniques regarding their efficacy and complication rates. The systematic review did not yield any prospective, controlled comparison studies. The systematic review revealed a lack of level 1 data comparing the different ptosis repair techniques. The authors concluded the level of evidence is an IV, poor quality and case-controlled series.

A 30-year review was completed and published in 2011 by Maffi et al. (6) A retrospective chart review of 3014 patients undergoing lower blepharoplasties, and after applying criteria 2007 were studied. After resolution of complications, the authors concluded that traditional lower eyelid blepharoplasty is safe and effective. Additionally, the routine use of additional tightening procedures to address inadequate lower eyelid tone is not necessary, whether combined internal and external approaches. The authors concluded the level of evidence is an IV, poor quality and case-controlled series.

A prospective case series was published by Li et al., in 2018. (7) In the comparison of 2 brow lift techniques, group A underwent resection of excess skin during brow lift surgery; group B underwent the new eyebrow lift technique, which involved resecting skin and the lateral part of the orbital orbicularis oculi muscle, elevating the lower margin of the orbital orbicularis oculi

muscle, and suturing it to the orbital periosteum. Eyebrow height and patient satisfaction were measured preoperatively and after surgery. Mean follow-up time was 24.8 months. Brow height was similar in groups A and B immediately postoperatively (group A: 28.37 Â± 3.02 mm [millimeters] versus group B: 29.21 Â± 2.97 mm) and at 6 months after operation (group A: 26.65 Â± 2.53 mm versus group B: 27.45 Â± 2.77 mm). At 12 months (group A: 22.73 Â± 2.31 mm vs group B: 25.61 Â± 2.62 mm) and 24 months (group A: 20.76 Â± 2.22 mm vs group B: 24.74 Â± 3.10 mm) after operation, the amount of brow elevation was significantly greater in group B.

Several reviews have been published regarding the diseases or conditions contributing to drooping eyelids, which include ectropion, entropion, ptosis, thyroid eye disease, facial palsy, and myasthenia gravis. (8, 9)

Ongoing and Unpublished Clinical Trials
An online search of ClinicalTrials.gov through February 21, 2023 identified no clinical trials that would likely influence this policy.

Practice Guidelines and Position Statements
American Society of Plastic Surgeons (ASPS)
The ASPS (10) created practice parameters or strategies for patient management related to blepharoplasty in 2007 and reaffirmed Dec. 2020. As of February 21, 2023, these guidelines are currently under review. The ASPS stated the following regarding the difference in functional and aesthetic reasons for blepharoplasty, “Functional issues include ptosis, floppy eyelid syndrome, blepharochalasis, dermatochalasis, herniated orbital fat, and visual field obstruction. Aesthetic reasons include a desire for a more youthful or less fatigued appearance.”

They further state the goals of operative treatments, “When there is a visual field impairment, blepharoplasty procedures are considered to be reconstructive. However, blepharoplasty procedures are most often performed to enhance appearance. The second most common cosmetic procedure in males is lower eyelid blepharoplasty.”

The ASPS included the following diagnostic criteria:

- *Preoperative Consultation*: “Patients present with a variety of symptoms or combination of symptoms including edema, visual field defects, hypertrophy of the orbicularis oculi, conjunctival inflammation, keratitis malar festoons, blepharochalasis, dermatochalasis, lagophthalmos, protrusion of orbital fat, eyelid ptosis, and eyebrow ptosis.”
- *Examination*: “Should include an evaluation of the amount of skin on the upper and lower lids; distribution of orbital fat; vector of the lower eyelid; and physical characteristics of the skin including degree of elasticity and pigmentation…., Ptosis of the upper lid is determined by measuring the palpebral fissure width and margin reflex distance. Levator excursion is also assessed. Visual field assessment is required for functional blepharoplasty. The forehead and eyebrow should be evaluated for brow ptosis.”

- *Photographs*: "Preoperative photographs may be used in patient assessment. 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."

American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS)

In 2015, the ASOPRS released a white paper on functional blepharoplasty, blepharoptosis, and brow ptosis repair. (11) The document included the following comments on recommended documentation requirements when submitting records and photographs for review:

1. Upper eyelid obstruction documentation should include:
   a. The patient's complaint of interference with daily visual tasks or visual field-related activities, and
   b. Visual obstruction due to excessive overhanging skin resting on or depressing the lashes or eyelid margin.
2. Upper eyelid ptosis documentation should include:
   a. The patient's complaint of interference with vision or visual field-related activities, and
   b. A margin to reflex distance (MRD) less than or equal to 2 mm in primary or downgaze.
   c. Visual obstruction due to ptotic upper eyelid.
   d. The position of one upper eyelid becomes more ptotic with an MRD of 2 mm or less when the other, more ptotic eyelid is elevated (i.e., Hering's Law).
3. Brow ptosis documentation should include:
   a. Brow ptosis to the extent it contributes to skin fold overlap and/or blepharoptosis.

Summary of Evidence

Blepharoplasty and brow ptosis repair are generally cosmetic procedures. However, blepharoplasty may be considered medically necessary procedures when there is documentation of significant visual impairments caused by the conditions listed in this policy. This medical policy has been developed through consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and government approval status.

Benefit determinations should be based in all cases on the applicable contract language. If there are any conflicts between these guidelines and the contract language, the contract language will prevail.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	15820, 15821, 15822, 15823, 21282, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67912, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67950, 67961, 67966
HCPCS Codes	None

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

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <http://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
05/15/2024	Reviewed. No changes.
05/01/2023	Document updated with literature review. Coverage unchanged. No new references added; one removed.
12/01/2022	Reviewed. No changes.
09/15/2021	Document updated with literature review. Coverage unchanged. Reference 2 and 10 updated.
10/15/2020	Reviewed. No changes.
04/01/2019	Document updated with literature review. Coverage unchanged. References added 7 and 11; none removed.
02/15/2017	Document updated with literature review. Coverage reorganized and unchanged, with clinical documentation requirements moved to the start of coverage section. Title changed from “Blepharoplasty, Blepharoptosis, Brow Repair.”
10/01/2016	The following changes were made to Coverage specific to the clinical documentation requirements outlined in section D: 1) Modified from “additional clinical documentation may be required” to “the following objective information is required”, 2) Removed requirement for “Medical record documentation of all eye care for the 24 months preceding the request for services.”, 3) Removed the parenthetical “not required if MRD documented <2 mm by photo or specific medical record examination note” from statement on visual field documentation.
07/15/2015	Reviewed. No changes.
08/15/2014	Document updated with literature review. The following was added to the coverage: 1) Blepharoplasty procedures of the upper eyelid may be considered medically necessary when additional documentation requirements outlined in section C below are met and the patient has any of the following: Clinically significant impairment of upper/outer visual fields (<30 degrees from fixation) by excessive upper eyelid skin (dermatochalasis) with historical medical record documentation of progressive degenerative changes of the eyelid skin inconsistent and in excess of the demographic norm of the requesting member, and accurate photo documentation of upper eyelid fold/redundant upper lid myocutaneous tissue that documents clear extension of upper lid fold over the lashes and infringing on the visual axis, or difficult prosthesis fitting in an anophthalmic socket because of drooping of the upper eyelid; or documented margin reflex distance -1

	(MRD-1) less than two millimeter (mm), either by photo or specific medical record examination note, severe corneal or conjunctival irritation caused by: Entropion, Ectropion, Trichiasis caused by entropion; or Periorbital sequelae of thyroid disease and/or nerve palsy; or painful symptoms related to blepharospasm, or visual symptoms of debilitating blepharospasm; or defects caused by trauma or tumor-ablative surgery. 2.) Additional documentation requirements: medical record documentation of all eye care for the 24 months preceding the request for services, reliable visual field documentation that suggests active, concurrent involvement of the patient (not required if MRD documented <2 mm by photo or specific medical record examination note), and full face frontal photo documentation, face plane parallel to film plan and visual axis perpendicular to film plan and centered in the camera lens. 3.) Blepharoplasty and ptosis procedures of the upper eyelid that do not meet the above criteria and/or is being performed primarily to improve appearance are considered cosmetic. CPT/HCPC code (s) updated.
09/15/2007	Revised/Updated Entire Document.
06/03/2005	CPT/HCPC code (s) updated
01/01/2005	Revised/Updated Entire Document.
07/01/2004	CPT/HCPC code (s) updated
05/01/1996	Revised/Updated Entire Document
01/01/1996	Revised/Updated Entire Document
07/01/1994	Revised/Updated Entire Document
05/01/1990	New Medical Document