Policy: MP010
Section: Medical Benefit Policy
Subject: Blepharoplasty

I. Policy: Blepharoplasty

II. Purpose/Objective:
To provide a policy of coverage regarding Blepharoplasty

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Blepharoplasty can be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. It may be either reconstructive or cosmetic. When blepharoplasty is performed to improve appearance in the absence of any documented functional abnormalities, the procedure is considered cosmetic. When blepharoplasty is performed to correct visual impairment caused by drooping eyelids (ptosis), repair defects caused by trauma or tumor-ablative surgery (ectropion/entropion corneal exposure), treat periorbital sequelae of thyroid disease and nerve palsy or the relief of painful blepharospasm, the procedure is considered to be reconstructive.

INDICATIONS: REQUIRES PRIOR MEDICAL DIRECTOR OR DESIGNEE AUTHORIZATION
The following indications may be considered medically necessary when the criteria for coverage are met:
- Pseudoptosis causing visual impairment
- True ptosis with dermatochalasis
- Primary idiopathic blepharospasm
- Cranial nerve palsy
- Thyroid disease
- Brow ptosis causing visual impairment

CRITERIA FOR COVERAGE:
The requesting provider must submit all of the following information:
- Visual fields
  Note: Visual fields must be recorded using either a tangent screen visual field, Goldmann Perimeter (III 4-E test object) or a programmable automated perimeter and demonstrate reproducible upper or temporal field loss within 30 degrees of fixation. Each eye should be tested with the upper eyelid at rest to demonstrate the degree of impairment. There is no need to tape the lids to demonstrate an expected surgical improvement.

The following indications may be considered medically necessary when physician generated documentation is provided to support any of the following conditions:
- Upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmic socket.
- Upper-eyelid defect caused by trauma, congenital defect, tumor or ablative surgery resulting in a severe lid deformity and functional visual impairment
- Essential blepharospasm or hemifacial spasm.
- Significant ptosis in the downgaze reading position.

EXCLUSIONS:
Blepharoplasty performed primarily for the purpose of enhancing one’s appearance is considered cosmetic surgery and is NOT COVERED.

Lower lid blepharoplasty is typically considered cosmetic and will not be covered. Individual consideration for medical necessity (e.g., neoplasm, ectropion, etc.) for lower lid blepharoplasty will be made by a Plan Medical Director.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: blepharoplasty
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

15820 Blepharoplasty, lower lid
15821 Blepharoplasty, lower lid; with extensive herniated fat pad
15822  Blepharoplasty; upper eyelid

15823  with excessive skin weighing down lid

67900  Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

67901  Repair of blepharoptosis; frontalis muscle technique with suture or other material

67902  frontalis muscle technique with fascial sling (includes obtaining fascia)

67903  (tarso) levator resection or advancement, internal approach

67904  (tarso) levator resection or advancement, external approach

67906  superior rectus technique with fascial sling (includes obtaining fascia)

67908  conjunctivo-tarso-Muller’s muscle-levator resection (e.g., Fasanella-Servat type)


LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


Novitas Solutions, Inc. Local Carrier Determination (LCD) for Surgery: Blepharoplasty (L35004). Accessed. 1/24/17

This policy will be revised as necessary and reviewed no less than annually.
Devised: 10/15/00

Revised: 08/08/01, 08/02 (criteria clarification); 5/03 (coding, definition), 5/04 (criteria clarification); 5/05; 5/06; 5/07, 5/08, 5/09 (coding), 5/10 (Ind. Wording), 5/12 (removed Intrinsic eyelid deformities indication), 6/13; 2/14 (update criteria); 2/16 (remove photograph requirement)

Reviewed: 5/11, 3/15, 2/17