Geisinger Health Plan Policies and Procedure Manual

Policy: MP010

Section: Medical Benefit Policy

Subject: Blepharoplasty, Blepharoptosis and Brow Ptosis Repair

Applicable line of business:

Commercial	**x**	**Medicaid**	**x**
Medicare	**x**	**ACA**	**x**
CHIP	**x**		

I. Policy: Blepharoplasty, Blepharoptosis and Brow Ptosis Repair

II. Purpose/Objective:

To provide a policy of coverage regarding Blepharoplasty, Blepharoptosis and Brow Ptosis Repair

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.

Commercial

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization

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
Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- 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.
Blepharoptosis is an abnormal low-lying upper eyelid margin with the eye in primary gaze. This condition can be the result of nerve palsy or dysfunction of the levator muscles. Brow ptosis is the decent of the brow and brow fat pad and occurs with advancing age or as the result of nerve or muscle dysfunction.

INDICATIONS: <u>REQUIRES PRIOR MEDICAL DIRECTOR OR DESIGNEE AUTHORIZATION</u>

<u>The following indications may be considered medically necessary when the criteria for coverage are met:</u>

- Pseudoptosis causing visual impairment
- True ptosis with dermatochalaisis
- Primary idiopathic blepharospasm
- Cranial nerve palsy
- Thyroid disease
- Brow ptosis causing visual impairment
- Repair defects caused by trauma or tumor-ablative surgery
- moderate to severe congenital ptosis in children under age 9 years to allow proper visual development and to prevent amblyopia.

CRITERIA FOR COVERAGE:

Blepharoplasty - Upper lid (15822, 15823):
The requesting provider must submit the following information:

- Documentation that redundant or drooping upper eyelid tissue is a primary contributory factor in the member’s visual field impairment; and
- Visual fields
  <u>Note</u>: 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.

Blepharoplasty – Lower lid (15820, 15821):
Lower eyelid blepharoplasty may be considered medically necessary for any of the following indications:

- Repair following tumor ablative surgery;
- Lower lid dysfunction resulting in the inability to close eye secondary to facial nerve damage;
- Corneal and/or conjunctival injury due to ectropion, entropion or trichiasis;
- Epiphora secondary to punctal eversion (ectropion)

Blepharoptosis repair (67901, 67902, 67903, 67904, 67906, 67908):
The requesting provider must submit the following information**:**

- Documentation that laxity or dysfunction of the muscles of the upper eyelid are causing functional impairment; and
- Documentation that the upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex (marginal reflex distance or MRD).

Brow ptosis repair (67900):

- Documentation that other causes of the visual field impairment have been ruled out; and
- 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.

Ectropion / Entropion Repair (67914-67917) (67921-67924)

Ectropion:

- Documentation of pain/discomfort or excessive tearing; and
- Kerato-conjunctivitis, keratitis or corneal ulcer

Entropion

- Documentation of inward-turned eyelid; and
- Irritation of the cornea or conjunctiva, pain/discomfort, excessive tearing, or trichiasis

Preoperative photographs

Preoperative photographs are optional. If requested to support medical necessity, submit the photographs in the form of prints or slides. Photograph guidelines that support medical necessity include:

- The photographs must be frontal view, canthus to canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash or position of the true lid margin or the pseudo-lid margin. The corneal light reflex should be present, unless covered by the eyelid.
- For CPT codes 15820-15823 or 67901-67908: If redundant skin coexists with true lid ptosis, take additional photos with the upper lid skin retracted to show the actual position of the true lid margin to support medical necessity.
- Oblique photos are only needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.
- Separate from the photographs, documentation in the medical record of the indicated distance thresholds (e.g., 2.5 mm or less from the central corneal reflex to the upper eyelid margin or skin that overhangs the eyelid margin [pseudoptosis]) is helpful to demonstrate medical necessity.

Note: If the provider chooses to submit pre-operative photographs, a narrative note must accompany the submission to support medical necessity.

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.

Canthoplasty/Canthopexy (21280, 21282)

- Reconstruction of the eyelid following surgical resection of lesions (benign or malignant) of the medial or lateral canthus; **or**
- as an adjunct to a medically necessary ectropion or entropion repair

For Commercial and Medicaid Business Segments:

Note: When both a Medically necessary blepharoptosis repair (67901-67908) and a medically necessary blepharoplasty (15822, 15823) are performed on the same eyelid in the same operative session the procedures are bundled and only one procedure (blepharoptosis repair or blepharoplasty) is reimbursed. The patient has no financial liability for the bundled service and a waiver does not apply. In contrast, the bundle does apply to a cosmetic blepharoplasty performed during the same session. For cosmetic procedures, provide a waiver to inform the patient for their financial liability.

For Medicare Business Segment – see also LCD L35004/A57618

If medical necessity is documented for both an upper eyelid blepharoplasty (15822, 15823) and a blepharoptosis repair (67901-67908) on the same eyelid the bundles apply and only one procedure is reimbursed. The member has no financial liability for the bundled service and a waiver does not apply. When a noncovered cosmetic procedure is performed in the same operative session on the same eyelid as a covered surgical procedure, the benefit will be applied for the covered procedure only. A pre-service organizational determination must be given to members to provide notification of financial liability for the cosmetic procedure and any items or services that Medicare never covers or for which Medicare is not likely to provide coverage.

Following CMS transmittal 3854 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3854CP.pdf), the bundle applies to the performance of a medically necessary upper eyelid blepharoplasty (15822, 15823) and a medically necessary blepharoptosis repair (67901 – 67908) in a single operative session. However, the bundles do not apply to cosmetic services performed in the same operative session with a medically necessary service. For example, the bundle does not apply to a cosmetic blepharoplasty performed on the same eye lid as a medically necessary blepharoptosis repair. For cosmetic procedures provide a pre-service organizational determination to inform the patient of their financial liability.

EXCLUSIONS:

Blepharoplasty and surgical procedures of the brow performed primarily for the purpose of enhancing one's appearance is considered cosmetic surgery and is **NOT COVERED**.

Upper eyelid "hooding" that is not contributory to the visual field impairment is considered cosmetic and is **NOT COVERED**.

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

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

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. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

15820 Blepharoplasty, lower lid
15821 Blepharoplasty, lower lid; with extensive herniated fat pad
15822 Blepharoplasty; upper eyelid
15823 with excessive skin weighing down lid
21280 medial canthopexy

21282 lateral canthopexy
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)
67909 reduction of overcorrection of ptosis
67911 correction of lid retraction
67914 repair of ectropion; suture
67915 repair of ectropion; thermocauterization
67916 repair of ectropion; excision tarsal wedge
67917 repair of ectropion; extensive (e.g., tarsal strip operations)
67921 repair of entropion; suture
67922 repair of entropion; thermocauterization
67923 repair of entropion; excision tarsal wedge
67924 repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)

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:
Baylis HI, Goldberg RA, Kerivan KM, Jacobs JL, "Analysis and Treatment of the Aging Face –Blepharoplasty and Periorbital Surgery" *Dermatologic Clinics,* Vol 15(4), Oct 1997.

Carter SR, "Eyelid Disorders:Diagnosis and Management" *American Family Physician*, June 1998, http://www.aafp.org/afp/980600ap/carter.html.

Gallo SA, Wesley RE, Klippenstein KA, Biesman BS, "Oculoplastic Surgery Update – Cosmetic Eyelid Surgery", *Ophthalmology Clinics of North America*, Vol.13(4), Dec. 2000.

American Society of Plastic Surgeons Position Paper, "Blepharoplasty & Eyelid Reconstruction:Recommended Criteria for Third-Party Payer Coverage.

Bashour,M, "Ptosis", http://www.emedicine.com/ent/topic97.htm

Bischel MD, "Ophthalmology Authorization Guidelines", *Medical Review Criteria Guidelines for Managed Care*, pp 390-391.

American Academy of Ophthalmology. Functional Indications for Upper and Lower Eyelid Blepharoplasty. *Ophthalmology* Apr. 1995;102(4):693-695.

Ho SF, Morawski A et al. Modified visual field test for ptosis surgery (Leicester Peripheral Field Test). Eye 2011;25(11):365-369.

Friedland JA, Lalonde DH, et al. An evidenced-based approach to blepharoplasty. Plast Reconstr Surg 2010;126:2222-2229.

Cahill KV, Bradley EA, Meyer DR, et al. Functional indications for upper eyelid ptosis and blepharoplasty surgery: A report by the American Academy of Ophthalmology. Ophthalmology. 2011;118(12):2510-2517.

Novitas Solutions, Inc. Local Carrier Determination (LCD) for Surgery: Blepharoplasty (L35004). Accessed. 1/24/17
Hahn S, Holds JB, Couch SM. Upper lid blepharoplasty. Facial Plast Surg Clin North Am. 2016;24(2):119-127

Wilson SC, Daar DA, Maliha SG, Abdou SA, Levine SM, Baker SC. Lower eyelid blepharoplasty: Does the literature support the longevity of this procedure? Aesthet Surg J. 2018;38(12):1289-1297

Kossler AL, Peng GL, Yoo DB, Azizzadeh B, Massry GG. Current trends in upper and lower eyelid blepharoplasty among American Society of Ophthalmic Plastic and Reconstructive Surgery members. Ophthalmic Plast Reconstr Surg. 2018;34(1):37-42

Hollander MHJ, Contini M, Pott JW, Vissink A, Schepers RH, Jansma J. Functional outcomes of upper eyelid blepharoplasty: A systematic review. J Plast Reconstr Aesthet Surg. 2019;72(2):294-309.

American Academy of Ophthalmology. Upper eyelid blepharoplasty. 2019 https://www.aao.org.

Hollander MHJ, Schortinghuis J, Vissink A, et al. Aesthetic outcomes of upper eyelid blepharoplasty: A systematic review. Int J Oral Maxillofac Surg. 2020;49(6):750-764.

Kim KK, Granick MS, Baum GA, et al. American Society of Plastic Surgeons evidence-based clinical practice guideline: Eyelid surgery for upper visual field improvement. Plast Reconstr Surg. 2022;150(2):419e-434e

Rodrigues C, Carvalho F, Marques M. Upper eyelid blepharoplasty: Surgical techniques and results -- Systematic review and meta-analysis. Aesthetic Plast Surg. 2023;47(5):1870-1883

American Association for Pediatric Ophthalmology and Strabismus. Patient Resources. https://aapos.org/patients/patient-resources

Oral, Y, Ozgur OR, et al. Congenital ptosis and amblyopia. J Pediatr Ophthalmol Strabismus. 2010 Mar-Apr;47(2):101-4.

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); 6/18 (clarification of criteria); 6/20 (add cathoplasty/canthopexy), 1/22(add photo requirement, blephartosis billing clarification); 1/23 (add entropion/ectropion indication criteria); 11/23 (update CMS process rules); 1/25 (add indications, lower lid criteria)

Reviewed: 5/11, 3/15, 2/17, 2/18, 5/19, 6/21

CMS UM Oversight Committee Approval: 12/23, 5/24, 02/25