Blepharoplasty & Brow Ptosis Repair

Origination: 06/16/09	**Revised:** 12/18/23	**Annual Review:** 11/12/24
Line of Business: Commercial Only ☐ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☒ Commercial, QHP/Exchange, & Medicare ☐		

Purpose:

To provide Blepharoplasty & Brow Ptosis repair guidelines for Population Health and Provider Alliances associates to reference when making benefit determinations.

Definition

- Blepharoplasty /Brow Ptosis repair is performed for either functional or cosmetic purposes.

Coverage Guidelines & Exclusion Criteria

A. **Blepharoplasty** is a covered benefit due to functional impairment and the following criteria are met:

   1. If the **primary indication is visual field obstruction, ALL** of the following criteria must be met:
      a. Visual field obstruction by lid without taping that limits upper field to within 30 degrees of fixation and;
      b. Visual field test with the eyelid taped shows improvement in the superior field of 10 degrees or more and;
      c. A photograph of the patient looking straight ahead must be provided:
      d. Submitted photos must be of sufficient clarity to show a light reflex on the cornea and demonstrate that the upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal reflex. If redundant skin co-exists with true lid ptosis, additional photos must be submitted with the upper lid retracted in order to show the true position of the true lid margin; **OR**
      e. If a Member meets these criteria (a, b, & c) in one (1) eye only and a bilateral blepharoplasty is planned, the opposite eye must have visual field obstruction without taping that limits upper field to within 40 degrees of fixation for both eyes to be covered;
   2. If the **primary indication is dermatochalasis,** then the above criteria also apply. In addition, a lateral photograph showing skin touching the eyelashes must be provided;

   3. *All other indications are not a covered benefit.*

B. **Brow Ptosis Repair** is a covered benefit when **ALL** of the following criteria are met:

   1. Visual field obstruction by brow without taping that limits upper field to within 30 degrees of fixation; **and**
   2. Visual field test with the brow taped shows improvement in the superior field of 10 degrees or more; **and**
   3. Photographs show the eyebrow below the supraorbital rim;
   4. *All other indications are not a covered benefit.*

C. **Lower Lid Blepharoplasty** is a covered benefit when documentation is provided that indicates ectropion, entropion or trichiasis. *All other indications are not a covered benefit.*

CPT Codes: 15822-15823, 67901-67908; 15822-15823 and 67903-904 are considered to be CCI edits according to CMS and are not separately reimbursable.

References:

1. American Academy of Ophthalmology. Functional indications for upper and lower eyelid blepharoplasty. Ophthalmology. 1995;102(4):693-695.

2. American Society of Plastic and Reconstructive Surgeons. Blepharoplasty Position Paper. Arlington Heights, IL: American Society of Plastic and Reconstructive Surgeons, Inc.; October 1990.

3. American Optometric Association. Care of the patient with amblyopia. Optometric Clinical Practice Guideline No. 4. 2nd ed. St. Louis, MO: American Optometric Association; 1997.

4. American Academy of Ophthalmology. Laser blepharoplasty and skin resurfacing. Ophthalmology. 1998;105(11):2154-2159.

5. Dailey RA, Saulny SM. Current treatments for brow ptosis. Curr Opin Ophthalmol. 2003;14(5):260-266.

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.