

## Corporate Medical Policy

### Reconstructive Eyelid Surgery and Brow Lift

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**Origination:** 1/2000  
**Last CAP Review:** 9/2011  
**Next CAP Review:** 9/2012  
**Last Review:** 9/2011

#### Description of Procedure or Service

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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. Eyelid surgery, or blepharoplasty may be performed for either functional, reconstructive or cosmetic purposes.

This document includes the following two sections specific to:

Section I - Blepharoplasty

Section II - Brow Lift

**\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

#### Policy

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**BCBSNC will provide coverage for Reconstructive Eyelid Surgery specifically Blepharoplasty and/or Brow Lift Surgery when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.**

#### Benefits Application

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This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

All blepharoplasty procedures may require Prior Review.

All brow lift procedures may require Prior Review.

#### Section I - Blepharoplasty

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Blepharoplasty is a surgical eyelid procedure that may be performed for functional, reconstructive or cosmetic purposes. The most common functional indication for blepharoplasty is a superior visual field defect secondary to redundant upper eyelid tissue (dermatochalasis) that overhangs the

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eyelid margin and in common usage, the term "blepharoplasty" usually refers to the operation performed for dermatochalasis. However, blepharoplasty also includes procedures performed to repair ptosis, eyelid retraction, entropion, ectropion, trichiasis, or defects following excision of tumors.

Visual field testing is a measurement of all of the area a person can see while they are facing forward with their eyes fixed on an object in front of them. It includes the area straight ahead as well as the peripheral vision. Visual field impairment may result in the need for functional blepharoplasty. Generally, lower eyelid blepharoplasty is performed for cosmetic purposes; however, there are functional indications for the procedure.

## When Blepharoplasty is covered

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The following procedures may be considered medically necessary when the criteria described below are met:

- A. Blepharoplasty procedures of the upper eyelid may be considered medically necessary for any of the following indications:

Clinically significant impairment of upper/outer visual fields (<30 degrees from fixation) by excessive upper eyelid skin (dermatochalasis). Visual fields must be extended by at least 15 degrees by raising the redundant upper eyelid tissue, as documented by either a Goldmann Perimeter or a programmable automated testing method. Photographs must be submitted and should be consistent with the degree of visual field impairment described in the medical records and demonstrated by the formal visual field testing.

1. Ptosis (blepharoptosis) repair for laxity of the muscles of the upper eyelid causing functional impairment. Records must document 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). Photographs must be submitted and should be consistent with the degree of visual field impairment described in the medical records and demonstrated by the MRD measurements.
2. The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmic socket.
3. To correct defects causing corneal or conjunctival irritation:
  - a. entropion - (eyelid turned inward)
  - b. pseudotrachiasis - (inward misdirection of eyelashes caused by entropion)
  - c. ectropion - (eyelid turned outward)
  - d. corneal exposure
4. To treat periorbital sequelae of thyroid disease and nerve palsy
5. To relieve painful symptoms related to blepharospasm or to relieve visual symptoms of debilitating blepharospasm.
6. To repair defects caused by trauma or tumor-ablative surgery.
7. To relieve chronic symptomatic dermatitis of pretarsal skin caused by redundant upper

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eyelid skin which has not been successfully treated by normal first line measures such as education regarding hygiene, antibiotics, etc. Documentation must include a description of onset; prior treatment; extent; and presence and description of discharge (amount, color, etc.).

- B. Blepharoplasty of the lower eyelid is generally considered cosmetic; however, lower eyelid blepharoplasty may be considered medically necessary for the following indications:
1. Facial nerve damage with inability to close eye due to lower lid dysfunction;
  2. Corneal and/or conjunctival injury or disease due to ectropion, entropion or trichiasis;
  3. Following tumor ablative surgery;
  4. Epiphora due to ectropion and/or punctal eversion.
- C. Documentation must include information relevant to the surgery proposed or performed; including the following as indicated:
1. Office records that indicate signs and symptoms of vision disturbance secondary to redundant or drooping upper eyelid tissue, including evaluation for Horner's syndrome. Patient complaints may include interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin, etc. For entropion, pseudotrachiasis, ectropion, and corneal exposure specific symptoms, duration and severity must be noted. (Required for all cases).
  2. Degree and description of visual impairment and marginal reflex distance. (Required for upper eyelid ptosis surgery.)
  3. Results from either a Goldmann Perimeter or a programmable automated perimeter visual field testing method. (Required for dermatochalasis surgery.)
  4. Photodocumentation (prints not slides) as indicated below:
    - i. Frontal photographs, 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.
    - ii. Close up lateral photographs with eyes open, upgaze and eyes closed.
    - iii. If redundant skin coexists with true lid ptosis, additional photos must be taken with the upper lid skin retracted to show the actual position of the true lid margin.
    - iv. Frontal and oblique photos are needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.

## **When Blepharoplasty is not covered**

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1. BCBSNC will not cover blepharoplasty **when performed primarily to improve appearance**. When the medical necessity criteria above are not met, it is considered cosmetic and excluded from coverage.
2. Lower lid blepharoplasty is generally considered cosmetic, except as noted above.

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## Section II – Brow Lift

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Brow ptosis refers to tissue laxity of the eyebrows and/or forehead. In extreme cases brow ptosis can obstruct the field of vision causing a functional impairment. Brow lift or "forehead lift" involves raising the eyebrow, forehead, and orbital region of the face. It often accompanies other plastic surgical procedures of the face, including cosmetic procedures of the eyelids, lower face and neck. It is generally performed to correct signs of aging (facial rejuvenation).

### When Brow Lift is covered

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Brow lift is generally considered cosmetic. However, for severe brow ptosis, brow lift may be considered medically necessary and eligible for coverage when **ALL** of the following criteria are met:

For severe brow ptosis, **ALL** of the following criteria must be met:

1. Office records that indicate signs and symptoms of vision disturbance secondary to redundant or drooping brow. Patient complaints may include interference with vision or visual field, difficulty reading or performing activities of daily living due to upper brow drooping, interfering with vision.
2. Clinically significant impairment of upper/outer visual fields (<30 degrees from fixation) by drooping brow. Visual fields must be extended by at least 15 degrees by raising the redundant brow tissue, as documented by either a Goldmann Perimeter or a programmable automated testing method; and
3. Clear documentation that visual field impairment cannot be corrected by upper lid blepharoplasty alone as shown by standardized methods of visual field testing; and
4. Photographs that show the eyebrows are below the supraorbital rim. Photographs before and after taping should show the functional effect of the proposed surgery. Lateral photographs must document the degree of hooding and relationship of brow to supraorbital rim.

### When Brow Lift is not covered

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BCBSNC will not cover brow lift surgery when performed primarily to improve appearance. In the absence of documentation of medical necessity, it is considered cosmetic and excluded from coverage.

### Policy Guidelines

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**All blepharoplasty and brow lift procedures are subject to medical review.**

### Billing/Coding/Physician Documentation Information for Reconstructive Eyelid and Brow Lift Procedures

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

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*Applicable service codes: 15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67914, 67916, 67917, 67921, 67923, 67924*

*Coverage eligibility requires documentation that the purpose of the surgery is to restore vision.*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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Physician Advisory Group - 1/90

Consultant Review

Medical Policy Advisory Group 3/99

Medical Policy Advisory Group 10/99

Medical Policy Advisory Group Approved policy - 4/20/2000

Specialty Matched Consultant Advisory Panel - 10/2000

Medical Policy Advisory Group - 10/2000

Specialty Matched Consultant Advisory Panel - 4/2001

Specialty Matched Consultant Advisory Panel - 9/2002

Federici, TJ, Meyer DR, Liniger LL. Correlation of the vision-related functional impairment associated with blepharoptosis and the impact of blepharoptosis surgery. *Ophthalmology*. (1999, September). 106(9);1705-1712.

Specialty Matched Consultant Advisory Panel - 3/2003

Specialty Matched Consultant Advisory Panel - 1/2005

American Academy of Ophthalmology (AAO). Functional indications for upper and lower eyelid blepharoplasty. *Ophthalmology*. 1995 Apr;102(4):693-5

Meyer DR (October 2002). Functional indications for eyelid surgery. *Review of Ophthalmology*, 9(10)Issue: 10/15/02. Retrieved on December 30, 2005 from [http://www.revophth.com/index.asp?page=1\\_211.htm](http://www.revophth.com/index.asp?page=1_211.htm)

Specialty Matched Consultant Advisory Panel - 1/2007

Specialty Matched Consultant review - 9/28/07

Specialty Matched Consultant review - 4/6/09.

American Society of Plastic Surgeons (ASPS). Practice Parameter for Blepharoplasty March 2007. Retrieved on August 18, 2010 from [http://www.plasticsurgery.org/Documents/Medical\\_Professionals/Blepharoplasty-Practice-Parameter.pdf](http://www.plasticsurgery.org/Documents/Medical_Professionals/Blepharoplasty-Practice-Parameter.pdf)

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Specialty Matched Consultant Advisory Panel review 9/2010

Specialty Matched Consultant Advisory Panel review 9/2011

## **Policy Implementation/Update Information**

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- 1/93 Revised: Coding revisions
- 2/96 Revised: Added ptosis responsible for loss of visual field
- 2/97 Reaffirmed
- 3/99 Review by MPAG. Reaffirmed.
- 5/99 Reformatted. Added neurological disease as possible contraindication and stated a requirement for physician documentation when ptosis occurs in one eye only; changed "Description of Procedure or Service", added Medical term definitions
- 3/00 Consultant review. Revised medical criteria for Blepharoplasty. Removed section referring to temporal upper and outer field measurements. Removed documentation reference to ptosis.
- 4/00 Added Medical Policy Advisory Group to the Scientific Background and Reference Sources section of the policy.
- 10/00 Specialty Matched Consultant Advisory Panel review. Changed criteria for "When Blepharoplasty is covered" to include additional criteria--repair of trauma or tumor-ablative surgery and corneal protection related to facial nerve palsy. Changed first statement in "When Blepharoplasty is not covered" for clarity. System coding changes. Medical Policy Advisory Group review. No further changes to criteria. Approve.
- 4/01 Specialty Matched Consultant Advisory Panel review. Added indication to when blepharoplasty is covered to indicate that the impairment of the upper/outer visual fields must be < 30 degrees from fixation. A paragraph was added to the Description section of the policy that defines visual field testing. Visual field was removed from the Medical Term Definitions section of the policy.
- 4/02 Format changes.
- 10/02 Specialty Matched Consultant Advisory Panel review. Added and/or to policy statement. Added marginal reflex distance as needed documentation under Billing and Coding section of policy. When Brow Lift is not covered clarified.
- 1/03 "When Blepharoplasty is Covered" criteria expanded to require marginal reflex distance. Added definition for marginal reflex distance. Source added.
- 1/04 Specialty Matched Consultant Advisory Panel review 3/2003. Policy name changed from "Blepharoplasty and Brow Lift" to "Reconstructive Eyelid Surgery and Brow Lift". Policy reformatted to include section I re: Blepharoplasty and section II re: Brow Lift. Benefits Application and Billing/Coding sections revised. Required Physician documentation revised. CPT code 15824 added to Billing/Coding section.
- 1/20/05 Specialty Matched Consultant Advisory Panel review 1/5/05. No changes to policy.

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5/19/05 Added codes 67914 and 67921 to Billing/Coding/Physician Documentation Information for Reconstructive Eyelid Surgery and Brow Lift.

10/2/06 Removed CPT code 15824 from Billing/Coding section. Code is not applicable to this policy.

12/11/06 Under Section I-Blepharoplasty; When Covered, A.6.clarified MRD reading "Records must document 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." Added A.8. "To relieve chronic symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin which has not been successfully treated by normal first line measures such as education regarding hygiene, antibiotics, etc. Documentation must include a description of onset, prior treatment, extent, presence and description of discharge, color, etc." Physician Documentation Information moved to Sections I and II When Covered sections as appropriate. Medical terms definitions added. (pmo)

11/5/07 Under Section I-Blepharoplasty introduction, clarified use of "blepharoplasty" in this policy. Under Section II-Brow Lift; When Covered, added bullet to clarify symptoms of visual disturbance that should be present secondary to redundant or drooping brow. Under Medical Term Definitions, clearer definition of MRD added. Reference sources added. (pmo)

4/27/09 Under When Covered section, A.5. changed to read "To relieve painful symptoms related to of blepharospasm, or to relieve visual symptoms of debilitating blepharospasm." Reference source added. (pmo)

6/22/10 Policy Number(s) removed (amw)

10/26/10 Reformatted and renumbered section "When Blepharoplasty is covered". Specialty Matched Consultant Advisory Panel review 9/2010. References updated. (mco)

10/11/11 Specialty Matched Consultant Advisory Panel review 9/2011. Description section for "Blepharoplasty" and "Browlift" updated.(mco)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.