MEDICAL MANAGEMENT DEPARTMENT
POLICY & PROCEDURE

Policy Title: Ptosis Surgical Procedures
Policy No: C.5.07
Date of Origination: February 19, 2001
Last Review: January 17, 2018

PROCEDURE:

A. Documentation Required:

In order to facilitate the authorization process referral requests must include the following:

1. Documentation of recurrent patient symptoms.

2. Documentation of physician exam which could include some or all of the following:
   a. Lid height or palpebral fissure height
   b. Levator function
   c. MRD index measurement
   d. Interpretation of visual fields

3. Photographs to support the symptoms and/or impairments reported by the patient:
   a. Primary gaze
   b. Downward gaze
   c. Upward gaze
   d. Side view

4. Visual field study, showing superior visual field with upper lid taped and un-taped (visual field testing may be omitted in infants and young children being treated for congenital ptosis)

B. Criteria for Medical Necessity:

Surgical reconstructive procedures for the following conditions are determined to be medically necessary based on the criteria below:

1. Unilateral or bilateral blepharoplasty and/or repair of blepharoptosis of the **upper eyelid** is medically necessary when **ALL** the following criteria are met (a – c):

   a. Patient history documents complaints of interference with vision or visual field related activities (headache, difficulty reading, difficulty seeing the superior visual field); **AND**

This Medical Policy is an example provided for informational purposes only. It does not constitute medical advice. This Medical Policy is property of Quartz Health Solutions, Inc. Unauthorized use and distribution is strictly prohibited. For copies of Medical Policies specific to your plan, please contact Medical Management at 888-829-5687.

b. Physician evaluation documents **ONE** of the following:
   i. Margin reflex distance (MRD) of 2.5 mm or less; **OR**
   ii. Visual fields document the superior visual field is limited to less than 30 degrees un-taped **AND** there is at least a 12 degree improvement in the taped visual field; **OR**
   iii. A palpebral fissure height on down-gaze of 1 mm or less; **AND**

c. Photographs must document and support the symptoms and/or impairments reported by the patient (e.g. upper eyelid skin rests on the eyelashes or over the eyelid margin).

Note: When only one upper eyelid meets the above criteria for medically necessary reconstruction, blepharoplasty or repair of blepharoptosis of the **contralateral upper eyelid** is considered to be medically necessary based on Hering's effect if the less ptotic lid meets **ANY** of the following (a – c) criteria:

a. MRD of 2.5mm or less; **OR**
b. Down-gaze MRD of 1.5mm or less; **OR**
c. Palpebral fissure width on down-gaze of 1mm or less.

2. Unilateral or bilateral blepharoplasty of the **upper eyelid** is medically necessary for **ANY** of the following conditions (a – e), without meeting the criteria from Section B.1:

   a. Repair of a defect that predisposes to corneal or conjunctival irritation:
      i. Corneal exposure
      ii. Ectropion (eyelid turned outward)
      iii. Entropion (eyelid turned inward)
      iv. Pseudotrichiasis (inward misdirection of eyelashes caused by entropion); **OR**
   b. Difficulty tolerating prosthesis in an anophthalmic socket; **OR**
   c. Nerve palsy; **OR**
   d. Periorbital sequelae of thyroid disease; **OR**
   e. Repair of a functional defect caused by trauma, tumor or surgery.

3. Unilateral or bilateral blepharoplasty of the **lower eyelid** is medically necessary for **ANY** of the following (a – d) conditions:

   a. Facial nerve damage with inability to close eye due to lower lid dysfunction; **OR**
   b. Corneal or conjunctival injury or disease due to ectropion, entropion; **OR**
   c. Trichiasis (ingrowing eyelashes); **OR**
   d. Following tumor ablative surgery.

4. Extended blepharoplasty, with wide resection of the orbicularis muscle complex, is considered medically necessary for primary essential idiopathic blepharospasm when other treatments have failed or are contraindicated (e.g. injection of Botulinum Toxin A).

5. Brow lift is medically necessary when **ALL** of the following criteria (a and b) are met:

   a. Brow ptosis is causing a functional impairment of upper/outer visual fields

This Medical Policy is an example provided for informational purposes only. It does not constitute medical advice. This Medical Policy is property of Quartz Health Solutions, Inc. Unauthorized use and distribution is strictly prohibited. For copies of Medical Policies specific to your plan, please contact Medical Management at 888-829-5687.

with documented patient complaints of interference with vision or visual field related activities; **AND**

b. Photographs document that the eyebrow is below the supraorbital rim.

C. Indications Considered Experimental, Investigational, or not Medically Necessary *(Not all inclusive)*:

1. Blepharoplasty, blepharoptosis repair, or brow lift are considered **cosmetic and not medically necessary** when performed to improve an individual's appearance in the absence of any signs or symptoms of functional abnormalities.

CPT/HCPCS Codes:

15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad.
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid with excessive skin weighting 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 (e.g., banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)

REFERENCES:

American Society of Plastic Surgeons. Practice Parameter for Blepharoplasty. March 2007.

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

Lucarelli, Mark MD, Department of Ophthalmology and Visual Sciences, UW School of Medicine and Public Health, November 2014.

WI Medicaid Forward Health Topic #13817: Restorative Plastic Surgery and Procedures.

WI Medicare LCD 34528 Blepharoplasty, Blepharoptosis and Brow Lift.

This Medical Policy is an example provided for informational purposes only. It does not constitute medical advice. This Medical Policy is property of Quartz Health Solutions, Inc. Unauthorized use and distribution is strictly prohibited. For copies of Medical Policies specific to your plan, please contact Medical Management at 888-829-5687.