# Clinical Policy: Blepharoplasty, Ptosis Repair and Canthoplasty

Reference Number: CP.VP.07 Coding Implications
Last Review Date: 12/2020 Revision Log

**See Important Reminder at the end of this policy for important regulatory and legal information.**

## Description

Upper eyelid blepharoplasties, ptosis repairs and canthoplasty procedures are utilized to alleviate obstruction of the visual field due to eyelid encroachment into the visual axis. This policy describes the medical necessity requirements for blepharoplasty ptosis repair and canthoplasty procedures.

## Policy/Criteria

**I.** It is the policy of health plans affiliated with Centene Corporation® (Centene) that blepharoplasty, ptosis repair and canthoplasty procedures are **medically necessary** for the following indications:

A. Blepharoplasty, upper eyelid, or repair of brow ptosis, all of the following:
   1. Visual obstruction defined by peripheral visual field testing consistent with a minimum of 12 degrees or 30% loss of upper field of vision, as demonstrated on taped and untaped peripheral visual field testing and photos in primary gaze
   2. Patient complaints of visual impairment secondary to abnormal eyelid or brow position resulting in limitation of daily activities such as reading, driving, and difficulty seeing objects approaching from the periphery, or redundant upper eyelid skin resulting in looking through the eyelashes or seeing the upper eyelid skin.

B. Blepharoptosis repair: all of the following:
   1. Visual obstruction defined by peripheral visual field testing consistent with a minimum of 12 degrees or 30% loss of upper field of vision, as demonstrated on taped and untaped peripheral visual field testing and photos in primary gaze
   2. Patient complaints of visual impairment secondary to abnormal eyelid or brow position resulting in limitation of daily activities such as reading, driving, and difficulty seeing objects approaching from the periphery, or redundant upper eyelid skin resulting in looking through the eyelashes or seeing the upper eyelid skin.
   3. Marginal reflex distance (MRD) of 2mm or less with gaze in primary position.

C. Canthoplasty (reconstruction of canthus), all of the following:
   1. As part of a blepharoplasty procedure to correct eyelids that sag to the extent that they pull down the upper eyelid causing visual field obstruction.

**II.** It is the policy of health plans affiliated with Centene that lower eyelid blepharoplasties are cosmetic and considered **not medically necessary.**

## Background

Upper eyelid blepharoplasty is a surgical procedure performed to remove redundant upper eyelid skin and/or excessive fat in patients with dermatochalasis. Patients who are candidates for blepharoplasty are patients whose dermatochalasis causes interference with vision or visual field, related to daily activities such as, difficulty reading, driving, watching television, or using a computer due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid

skin, or brow fatigue. Patients might describe the need to manually elevate their eyelid to see and also might experience a brow ache or headache from constant brow elevation, adopt a compensatory chin elevation, or bump their head on overhead objects.

Patients with ptosis or dermatochalasis may also complain of seeing their own lashes or feeling them irritating their cornea. Elevation of the lid via neosynephrine does not substantially improve these patients, as the skin remains redundant and overhanging. Patients who have normal lid margin position but severe dermatochalasis are candidates for blepharoplasty alone. Patients who undergo upper lid ptosis are not automatically candidates for simultaneous blepharoplasty simply because a small amount of skin is removed as part of the procedure.

Repair of brow ptosis may be considered medically necessary when documentation demonstrates brow ptosis to the extent it contributes to skin fold overlap and/or blepharoptosis meeting the criteria outlined below for upper eyelid blepharoplasty and/or ptosis surgery. Blepharoptosis (ptosis) repair is a surgical procedure performed to elevate the upper eyelid margin in patients with congenital or acquired ptosis and can be accomplished by procedures such as external levator resection or advancement, posterior approach Muller's muscle and conjunctival resection, or frontalis suspension.

Canthoplasty is considered medically necessary as part of a blepharoplasty procedure to correct eyelids that sag so much that they pull down the upper eyelid so that vision is obstructed.

Ptosis is a downward displacement of the upper eyelid margin due to congenital defect, inflammation, nerve disorder, traumatic deformity, myogenic, mechanical or age related degenerative changes of the eyelid and supporting structures. Dermatochalasis is excessive eyelid skin, usually the result of the aging process with loss of elasticity. Dermatochalasis may also result from specific disorders, such as thyroid eye disease, floppy eyelid syndrome, blepharochalasis syndrome, trauma, or any condition that causes stretching of the upper eyelid skin.

Canthoplasty, also known as inferior retinacular suspension or lateral retinacular suspension, involves tightening the muscles or ligaments that provide support to the outer corner of the eyelid. This procedure may be medically necessary where drooping of the outer corner of the eyelid interferes with vision.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| CPT® Codes | Description |
|---|---|
| 15820* | Blepharoplasty, lower eyelid |
| 15821* | Blepharoplasty, lower eyelid; with extensive herniated fat pad |
| 15822 | Blepharoplasty, upper eyelid |
| 15823 | Blepharoplasty, upper eyelid 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 (eg banked fascia) |
| 67902 | Repair of Blepharoptosis; frontalis muscle technique with autologous 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 |
| 67906 | Repair of Blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia) |
| 67908 | Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle levator resection (eg Fasanella-Servat type) |
| 67909 | Repair of Blepharoptosis; conjunctivo-taro-Muller's muscle levator resection (eg Fasanella-Servat type) |
| 67911 | Correction of lid retraction |
| 67950 | Canthoplasty (reconstruction of canthus) |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**
+ Indicates a code requiring an additional character

| ICD-10-CM Code | Description |
|---|---|
| H02.31 | Blepharochalasis right upper eyelid |
| H02.34 | Blepharochalasis left upper eyelid |
| H02.401 | Unspecified ptosis of right eyelid |
| H02.402 | Unspecified ptosis of left eyelid |
| H02.403 | Unspecified ptosis of bilateral eyelids |
| H02.411 | Mechanical ptosis of right eyelid |
| H02.412 | Mechanical ptosis of left eyelid |
| H02.413 | Mechanical ptosis of bilateral eyelids |
| H02.421 | Myogenic ptosis of right eyelid |
| H02.422 | Myogenic ptosis of left eyelid |
| H02.423 | Myogenic ptosis of bilateral eyelids |
| H02.511 | Blepharophimosis right upper eyelid |
| H02.512 | Blepharophimosis right lower eyelid |
| H02.514 | Blepharophimosis left upper eyelid |
| H02.515 | Blepharophimosis left lower eyelid |
| H02.431 | Paralytic ptosis of right eyelid |
| H02.432 | Paralytic ptosis of left eyelid |

| ICD-10-CM Code | Description |
|---|---|
| H02.433 | Paralytic ptosis of bilateral eyelids |
| H02.831 | Dermatochalasis of right upper eyelid |
| H02.834 | Dermatochalasis of left upper eyelid |
| H57.811 | Brow ptosis, right |
| H57.812 | Brow ptosis, left |
| H57.813 | Brow ptosis, bilateral |
| Q10.0 | Congenital ptosis |
| Q10.1 | Congenital ectropion |
| Q10.2 | Congenital entropion |
| Q10.3 | Other congenital malformations of eyelid |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
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**References**

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6. American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) White Paper on Functional Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair. November 24, 2014. https://www.asoprs.org/assets/docs/1%20-%20FINAL%20ASOPRS%20White%20Paper%20January%202015.pdf

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs,

and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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