BLEPHAROPLASTY, BLEPHAROPTOSIS AND BROW PTOSIS REPAIR

Protocol: SUR050  
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INSTRUCTIONS FOR USE

This protocol provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Evidence of Coverage (EOC)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this protocol. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Protocol. Other Protocols, Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Protocols, Policies and Guidelines as necessary. This protocol is provided for informational purposes. It does not constitute medical advice.

COMMERCIAL COVERAGE RATIONALE

Upper eyelid blepharoplasty, blepharoptosis and/or brow ptosis repair are reconstructive and medically necessary procedures when the following criteria are met:

1. The patient must have a functional/physical impairment complaint directly related to an abnormality of the eyelid(s) AND
2. Provider documentation of dermatochalasis/blepharochalasis (excess skin) or upper eyelid ptosis (eyelid droop) and an MRD-1 of 2.5mm or less, AND
3. High quality photographs which demonstrate that the upper eyelid margin or “false margin” in the case of severe dermatochalasis/blepharochalasis obscures at least ¼ of the diameter of the visible upper iris (this is approximately equal to an MRD-1 of 2.5mm). The date taken and the service reference identification number (obtained at time of
notification) or patient’s name and ID number must be documented on the photograph(s); AND

4. Superior visual field testing, with the eyelids taped and untapped, showing improvement of 12 degrees or greater, or 30% or more improvement of overall superior visual field.

**Brow Ptosis** is considered reconstructive and **medically necessary** only when the following criteria are present:

1. Provider must document a functional complaint related to brow droop and objective findings of brow droop AND
2. High quality photographs with the brow at rest and with the brow elevated. The at-rest photograph must show that most of the eyebrow is below the superior orbital rim and is causing a collection of excess skin and/or droop of the upper eyelid. The photograph with the brow elevated must show that the excess skin and/or the upper eyelid margin are no longer obscuring the upper iris, e.g., elevation of the brow helps resolve the eyelid abnormality that is causing the visual field defect. AND
3. Superior visual field testing, with the **eyelids** taped and untapped, (taping the eyelids simulates the effect of a brow lift) showing improvement of 12 degrees or greater, or 30% or more improvement of overall superior visual field.

**COMMERCIAL COVERAGE: REQUIRED DOCUMENTATION**

The decision regarding whether the requested procedure will be covered as a reconstructive and medically necessary procedure or excluded from coverage as cosmetic will require review of the following required clinical information/documentation:

1. Contemporaneous physician office notes to include all of the following:
   a. The enrollee’s chief complaint on the initial evaluation/office visit, and
   b. History of the medical condition(s) requiring treatment or surgical intervention, and
   c. Examination including objective findings of eyelid, brow or other abnormalities associated with the patient’s complaints and objective measurements including marginal reflex distance-1 (MRD-1)

2. Appropriate clinical studies/tests addressing physical and/or physiologic abnormality (visual field testing with eyelids taped and untapped)
   - Visual field testing must be performed on either a Goldmann Perimeter or a programmable automated perimeter or tangent screen that tests the superior visual field out to at least 50 degrees above fixation. Each eye should be tested with the upper eyelid at rest and then repeated with the eyelid elevated (e.g. taped or manually retracted) to demonstrate an expected “surgical” improvement.

3. High-quality photographs, documenting the physical and/or physiologic abnormality accounting for the functional impairment (as defined in the Definition section below). The date taken and the service reference identification number (obtained at the time of notification) or patient’s name and ID number must be documented on the photograph(s). Full face photographs must be frontal and lateral canthus to lateral canthus with the head
perpendicular to the plane of the camera (i.e. not tilted). The photographs must be of sufficient clarity to show light reflex on the cornea OR the relationship of the true eyelid margin or the “false lid margin” in the case of severe dermatochalasis/blepharochalasis to the iris or pupil.

**Visual Field Exceptions:**

The following may be considered reconstructive and do not require all of the documentation above.

**A. Eyelid surgery with an anophthalmic socket** (has no eyeball). (visual fields are not required for eyelid surgery when anophthalmic socket is present).

1. Provider documents anophthalmic condition, **and**
2. Patient is experiencing difficulties wearing an ocular prosthesis, **and**
3. Provider documents that the difficulty wearing the prosthesis is caused by an eyelid mal-position, **and**
4. High quality photographs documenting the eyelid mal-position.

**B. Lower eyelid surgery** is considered reconstructive only when the following criteria are present. (Visual fields are not required for lower eyelid surgery.)

1. Lower eyelid blepharoplasty (CPT 15820 and 15821) are usually cosmetic. All requests for these codes must be reviewed by a Medical Director.
2. Provider must document a functional complaint related to lower eyelid mal-position and objective findings consistent with the abnormality:
   a. Presence of Ectropion (eyelid turned outward) with epiphora and/or keratoconjunctivitis; (CPT 67914 through 67917) **or**
   b. Presence of Entropion (eyelid turned inward) with trichiasis which is causing irritation of the cornea or conjunctiva (CPT 67921 through 67924) **and**
   c. High quality photographs documenting the lower eyelid abnormality

**C. When Patient is not Capable:**

1. Visual field test for upper eyelid blepharoplasty or blepharoptosis repair or brow lift surgery is not required when the patient is not capable of performing a visual field test. The following are some examples:
   a. If the patient is a child 12 years old or under,
   b. If the patient has mental retardation or some other severe neurologic disease.
2. If the patient cannot perform the visual field test, coverage will be determined on the basis of clinical notes documenting eyelid abnormality, MRD-1 of 2.5mm or less and photographs confirming the eyelid abnormality.
MEDICARE & MEDICAID COVERAGE RATIONALE

Medicare does not have a National Coverage Determination for Blepharoplasty and Brow Ptosis Repair.

There is a Local Coverage Determination (LCD) for Nevada for Blepharoplasty, Blepharoptosis and Brow Lift (L28239). The LCD is as follows:

**Indications and Limitations of Coverage and/or Medical Necessity**

Blepharoplasty, blepharoptosis and lid reconstruction may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. They may be either functional/reconstructive or cosmetic.

**Upper blepharoplasty** (removal of upper eyelid skin) and/or repair of blepharoptosis should be considered functional/reconstructive in nature and **medically necessary** when the upper lid position or overhanging skin is sufficiently low to produce functional deficit, usually related to visual field impairment whether in primary gaze or down-gaze reading position.

**Upper blepharoplasty may also be indicated** for chronic dermatitis due to redundant skin.

**Blepharoptosis surgery may be indicated** in patients with an anophthalmic socket experiencing ptosis or prosthesis difficulties. Brow ptosis (i.e., descent or droop of the eyebrows) can also produce or contribute to functional impairment.

Reasonably complete information fulfilling the criteria in section A (patient signs and symptoms), section B (photographs), and section C (visual field) as listed below must be documented in the medical record in order to demonstrate medical necessity of the proposed procedure. They need not be submitted with the claim, but must be available upon request.

A. **Documentation** in the medical records must include patient complaints and findings secondary to eyelid or brow malposition such as:

1. Interference with vision or visual field related activities such as, difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue or difficulty fitting spectacles due to excessive eyelid tissue.
2. Chronic eyelid dermatitis due to redundant skin.
3. Difficulty wearing a prosthesis (V52.2).
4. Margin reflex distance (MRD) of 2.0 mm or less. (The margin reflex distance is a measurement from the corneal light reflex to the upper eyelid margin with the brows relaxed.). The distance from 1.0-2.0mm remains a "grey area." Providers must maintain adequate documentation of **functional** problems in considering such patients for blepharoplasty.
5. A palpebral fissure height on down-gaze of 1 mm or less. (The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated.)
6. The presence of Herring's effect meeting one of the above two (#4 or 5) criteria. (Herring's law is one of equal innervation to both upper eyelids and is considered in the documentation to perform bilateral ptosis in which the position of one upper eyelid has marginal criteria and the other eyelid has good supportive documentation for ptosis surgery. In these cases, the surgeon can lift the more ptotic lid with tape or instillation of Phenylepherine drops into the superior fornix. If the less ptotic lid then drops downward according to Herring's law to the point of an MRD of 2.0 mm or less or a down-gaze MRD of 1.5 or less or a palpebral fissure width on down-gaze of 1 mm or less, then the less ptotic lid would be considered for surgical correction.)

B. Photographs and medical record documentation must demonstrate at least one of the following:
(Digital or film photographs are acceptable)
1. For Blepharoptosis Repair - photographs of both eyelids in the frontal, straight-ahead position and down-gaze should be taken.
2. For Blepharoplasty Repair: Oblique or lateral photos are needed to demonstrate redundant skin on the upper eyelids (when redundant skin is the problem), in addition to frontal photographs.
   a. Upper eyelid skin resting on the eyelashes or over eyelid margin
   b. Upper eyelid dermatitis secondary to redundant skin
   c. Dermatochalasis (ICD-9-CM code 374.87)
   d. When the primary problem is related to lateral visual field deficit, superior extent of the lateral visual field less than 20 degrees above the horizontal meridian would be sufficient to justify blepharoplasty.
3. For Brow Ptosis Repair: Photographs should document medical necessity for brow ptosis repair (drooping of brows and improvement of blepharoptosis or dermatochalasis/blepharochalasis by elevation of brows). In addition, frontal photographs are necessary.

C. Visual fields
1. The indication for surgery is supported if a difference of 12 degrees or more or a 30% superior visual field difference demonstrated between visual field testing before and after manual elevation of the eyelids, or if there is an absolute superior defect to within 15 degrees of fixation.
2. Visually significant brow ptosis may be documented by visual field testing with the brow elevated demonstrating a difference of 12 degrees or more or 30% superior visual field difference, or if there is an absolute superior defect to within 15 degrees of fixation.
3. Visual fields need to meet accepted quality standards, whether they are performed by Goldmann technique or by use of a standardized automated technique, or by use of tangent screen fields.
4. Visual fields are not necessary for patients with an anophthalmic socket who are experiencing ptosis causing difficulty with their prosthesis.

D. Relief of eye symptoms associated with blepharospasm (333.81). Primary essential idiopathic blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. If other treatments have failed or are
contraindicated an extended Blepharoplasty with wide resection of the orbicularis oculi muscle complex may be medically necessary.

When Blepharoplasty is performed to improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities, the procedure is considered cosmetic and not covered by Medicare.

Lower lid Blepharoplasty is considered non-payable by Medicare, as it is generally considered to be cosmetic. CPT 15820 and 15821 will be denied as a non-covered service (cosmetic) though the codes are included in the CPT/HCPCS codes list below.

Blepharitis/dermatitis codes (373.00-373.8) do not justify blepharoplasty. These codes are considered non-payable.

Note: When a noncovered cosmetic procedure is performed in the same operative session as a covered surgical procedure, benefits will be provided for the covered procedure only.
**General Information:**

**Documentation Requirements**

1. The patient medical records should be legible, contain the relevant history and physical findings conforming to the criteria stated in the Indication and Limitations of Coverage and/or Medical Necessity sections A-D of this policy. Copies of the following must be made available to this A/B MAC on request only:

   a. Pre-operative exam, Photographs: Submitted photographs must be frontal and canthus-to-canthus with the head perpendicular to the plane of the camera (i.e., not tilted) in order to demonstrate the position of the true lid margin or the "false lid margin" in the case of pseudoptosis caused by severe dermatochalasis.

   b. Visual fields: Visual field studies must contain the beneficiary's name, the date, and the eye(s) tested. Visual fields are not required when the reason for the lid surgery is entropion or ectropion.

   c. Operative report

2. The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

3. When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.

4. When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

**For Medicare and Medicaid Determinations Related to States Outside of Nevada:**

Please review Local Coverage Determinations that apply to other states outside of Nevada.


**Important Note:** Please also review local carrier Web sites in addition to the Medicare Coverage database on the Centers for Medicare and Medicaid Services’ Website.
BACKGROUND

The eyelid is made up of the thinnest skin on the face and is likely to be the first facial feature to reveal signs of aging. Dermatochalasis (sagging of the eyelids) is a common, physiologic condition. Dermatochalasis is typically bilateral and most often seen in patients over 50 years of age, but may infrequently occur in some younger adults. Rarely, systemic disorders such as Ehlers-Danlos syndrome, cutis laxa, thyroid eye disease, renal failure and amyloidosis may hasten the development of dermatochalasis and ptosis (DeAngelis, 2002).

Inspection of these patients' eyelids reveals redundant, lax skin with poor adhesion to the underlying muscle and connective tissue. An excess flap or fold of skin in the upper lid is characteristic, and the normal upper lid crease may be lost. Dermatochalasis typically results in ptosis of the eyelids (or blepharoptosis). The eyelid normally covers one to two millimeters of the upper limbus of the cornea (Nelson, 2003). Dermatochalasis can cause a lid to cover more than the upper limbus and result in both functional and aesthetic deformities. Occasionally some patients will utilize the frontalis muscle to pull the lids open. This eliminates the ptosis but results in wrinkling or furrowing of the forehead.

Functional deficits may result from other eyelid deformities such as congenital abnormalities, trauma or following surgical interventions. Blepharoplasty may also be indicated to treat inflammatory disorders of the eye, orbit or eyelids as a result of conditions such as Graves' ophthalmopathy or chronic papillary conjunctivitis. If left untreated, entropion (eyelid turns inward toward the eye), ectropion (eyelid turns away from the eye), or facial nerve paralysis may result in inflammation of the cornea, and/or cornea erosion. Entropion, ectropion, and facial nerve disorders may be present in either the upper or lower eyelids.

Dermatochalasis may be a cosmetic concern only when it does not affect vision. Wrinkled folds of skin on the upper eyelids, bags under the eyes and sagging eyebrows can make a person look older, tired or sad. However, some patients report true functional difficulties. The most common impairment is obstruction of the superior visual field due to the redundant tissue that overlaps or hoods the eye. Ocular irritation secondary to misdirected lashes or chronic blepharitis is a less common complaint (Fay, 2003).

Brow ptosis refers to the laxity of muscles and sagging tissue of the eyebrows and/or forehead. It is a common age related change, but also can occur with facial palsy and paralysis of the brow elevator frontalis muscle. The usual location of the brow is at the periorbital rim. The muscle laxity may alter the position of the eyebrow. Repair of dermatochalasis and/or blepharoptosis in the presence of an untreated brow ptosis may result in incomplete resolution of the visual impairment. Also failure to excise redundant upper eyelid tissue at the time of brow ptosis repair (browplasty) may accentuate the tissue overhanging the eyelid margin.

Blepharoplasty is a surgical procedure in which redundant tissue of skin, muscle or fat are excised from the upper or lower eyelid. It is defined by the American Society of Plastic and Reconstructive Surgeons (ASPRS) as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. It may be either reconstructive or cosmetic (aesthetic). According to the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) survey, blepharoplasty is the most requested facial cosmetic surgical procedure.
Reconstructive surgery corrects a physical defect of the eyelid due to trauma, infection, inflammation, degeneration, neoplasia or developmental errors in order to improve or restore eye function and/or field of vision. Reconstructive blepharoplasty is performed most commonly to improve a superior vision field loss due to redundant upper eyelid tissue that overhangs the eyelid margin resulting in restriction of upward gaze and/or blocking of peripheral vision. The abnormal weight of the excess tissue may cause the eyelid sag, but there commonly is a concomitant ptosis (blepharoptosis) caused by weakness in the levator muscle. Functional improvement of vision or eye function should result from correction of the deficit with reconstructive procedures. If weakness in the levator muscles exists, surgical correction of the brow ptosis and the blepharoplasty may be done at the same time.

When surgery is performed to improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities, the procedure is cosmetic (AAFPRS). A brow lift that is performed to raise drooping brows and remove excess skin to produce a smooth appearance of the forehead without correcting a visual impairment would be considered a cosmetic procedure. Excess fat, tissue, skin or sagging muscles beneath the eye rarely obstructs vision to cause a visual impairment, so a lower eyelid blepharoplasty is usually cosmetic.

There are at least three situations in which a functional lower eyelid blepharoplasty is indicated. One is lower eyelid edema that may be secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome or a number of other metabolic or inflammatory disorders. The second situation in which a lower eyelid blepharoplasty may be required is in cases of epiblepharon or entropion in which the extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea (American Academy of Ophthalmology). The third common situation requiring lower lid blepharoplasty is in cases of ectropion in which the lower lid hangs open enough to allow drying of the conjunctiva and lower cornea causing conjunctivitis and/or keratitis.

The preoperative evaluation should include documentation of the functional impairment (Putterman). The amount of ptosis is documented by the margin-to-reflex distance 1 (MRD1) which is the distance from the central pupillary light reflex to the upper eyelid margin. The margin-to-reflex distance 2 (MRD2) is the distance from the central pupillary light reflex to the lower eyelid margin. The MRD1 plus the MRD2 should equal the palpebral fissure measurement. As ptosis of the lower lid rarely obscures vision, the MRD1 is the critical measure. An MRD1 measurement that is greater than or equal to 2.5 mm is considered normal. Most practitioners recommend taping the eyelid in an upward position and repeating the MRD1 to determine if this increases the distance to document that the procedure would result in an improvement of the impairment (Dresner, 2001).

The levator excursion is the best clinical test of levator function. The levator excursion is documented in millimeters, measuring the distance from extreme up gaze to down gaze with the brow immobilized by the examiner's thumb to eliminate any contribution of the brow to lid elevation. A millimeter ruler is used vertically in the papillary axis to assess the full excursion (Dresner, 2001).

The visual field is the range that a person can see while fixating the eye on an object. Accurate documentation of visual fields requires kinetic testing with a tangent screen, Goldmann's perimeter, or automated threshold perimeter. The latter involves the use of a computer and the comparison of an individual patient's visual field with the expected normal values from a nondiseased population. A
superior visual field defect was quantified by Meyer et al. Impairment of the superior visual field ranged from 20% for mild ptosis to 54% in advanced cases where the eyelid crosses the middle of the pupil. Other authors measure visual field deficits by a physical measurement of the amount of eyelid droop. Drooping of the upper eyelid may be minimal (1-2 mm), moderate (3-4 mm), or severe (>4 mm), covering the pupil entirely (Finsterer, 2003). However, the patient could impact the measurement by lowering their lids during this test.

**CLINICAL EVIDENCE**

Cahill et al. (1987) measured the upper eyelid position, pupillary diameter, and visual field impairment in 26 eyes with adult-onset blepharoptosis and determined that the distance between the upper lid and the central corneal reflex was the most useful measurement for predicting visual field impairment. Superior visual field impairment was present when the distance between the upper lid and the central corneal reflex was less than 2.5 mm.

Small et al. (1989) recorded the measurements of 242 ptotic and normal eyelids and compared the results with algebraically derived measurements from projected 35 mm photographs. Accuracy to 1.5 mm or better was obtained in 84% of clinical as compared with photographic measurements. Ptosis was defined as present when the upper eyelid is less than 2 mm from midpupil. Reduction of the upper field of vision to 30 degrees or less was present in 97% of eyes with ptosis so defined. Although ptosis is best defined in terms of the midpupil to upper lid distance, the diagnosis of ptosis rests with the examining physician based on the clinical evaluation of the patient.

Levator excursion of 10 mm or greater is considered good function, 5-9 mm of excursion is fair function and 4 mm or less is poor function (Dresner, 2001).

**DEFINITIONS**

**Blepharochalasis:** relaxation of the skin of the eyelid due to recurrent edema

**Blepharoplasty:** a surgical procedure in which redundant tissue of skin, muscle or fat are excised from the upper or lower eyelid.

**Brow ptosis:** a condition in which the eyebrow droops or sags.

**Canthus:** either of the corners of the eye where the upper and lower eyelids meet.

**Congenital Anomaly:** a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

**Cosmetic Procedures:** Cosmetic Procedures are excluded from coverage. Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a bodily function are excluded. Cosmetic procedures include:

- Surgery for sagging or extra skin,
• Any augmentation or reduction procedures,
• Rhinoplasty and associated procedures, and
• Any implant utilizing an implant which does not alter physiologic functions unless medically necessary.

Psychological factors (example: for self-image, difficult social or peer relations) do not constitute restoring a physical bodily function and are not relevant to such determinations. (HPN Generic Evidence of Coverage, modified 2009)

**Cosmetic Surgery:** defined by the American Society of Plastic Surgeons, "is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."

**Dermatochalasis:** fine wrinkling and loosening of the eyelid skin

**Ectropion:** a medical condition in which the lower eyelid turns outwards.

**Entropion:** a medical condition in which the eyelids fold inward.

**Epiphora:** is overflow of tears onto the face. A clinical sign or condition that constitutes insufficient tear film drainage from the eyes in that tears will drain down the face rather than through the nasolacrimal system.

**Frankfurt Horizontal:** a horizontal plane represented in profile by a line between the lowest point on the margin of the orbit and the highest point on the margin of the auditory measure.

**Functional/Physical Impairment:** A physical/functional or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

**High Quality Photograph:** ideally a high-quality print should be in color have at least 200 pixels per inch. It must be detailed enough to show the patient’s anatomy that is described in the physician’s office notes. If submitted as a hard copy, the image must be on photographic paper.

**Illness:** Illness means an abnormal state of health resulting from disease, sickness or malfunction of the body; or a congenital malformation, which causes functional impairment. For purposes of this EOC, Illness also includes sterilization or circumcision. Illness does not include any state of mental health or mental disorder other than Mental Illness as it is defined in this EOC. (HPN Generic Evidence of Coverage, modified 2009).

**Keratoconjunctivitis:** is inflammation of the cornea and conjunctiva.

**Margin Reflex Distance 1 (MRD-1):** measures the number of millimeters from the corneal light reflex or center of the pupil to the upper lid margin.
**Marginal Reflex Distance – 2 (MRD-2):** measures the number of millimeters from the corneal light reflex or center of the pupil to the lower lid margin

**Reconstructive Procedures:** defined under Cosmetic surgery.

**Reconstructive Surgery:** defined by the American Society of Plastic Surgeons, "is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance."

**Trichiasis:** is a medical term for abnormally positioned eyelashes that grow back toward the eye, touching the cornea or conjunctiva.

**Visual field:** the total area where objects can be seen in the peripheral vision while the eye is focused on a central point

**Visual Field Test:** measures how much 'side' vision a person has. Other names for this test may include Perimetry, Tangent screen exam, Automated perimetry exam, Goldmann visual field exam, or Humphrey field exam.
### APPLICABLE CODES

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document. This list of codes may not be all inclusive.

#### CODING for COMMERCIAL LINE OF BUSINESS

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Blepharoplasty</strong></td>
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<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
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<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive herniated fat pad</td>
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<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
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<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
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<tr>
<td><strong>Brow Ptosis Repair</strong></td>
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<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraclial, mid-forehead or coronal approach)</td>
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<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)</td>
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<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
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<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach</td>
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<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
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<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
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<td>Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)</td>
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<td>Reduction of overcorrection of ptosis</td>
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<td>Repair of Ectropion; Thermocauterization</td>
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<td>67916</td>
<td>Repair of Ectropion; Excision tarsal wedge</td>
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<td>67917</td>
<td>Repair of Ectropion; Extensive (e.g, tarsal strip operations)</td>
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<td><strong>Entropion</strong></td>
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<td>Repair of Entropion; Suture</td>
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<td>67923</td>
<td>Repair of Entropion; Excision tarsal wedge</td>
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<td>67924</td>
<td>Repair of Entropion; Extensive (e.g, tarsal strip operations or capsulopalpebral fascia repairs operation)</td>
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## CODING for MEDICARE LINE OF BUSINESS

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<tr>
<td>Note: CPT codes 15820 and 15821 are non-covered and will be denied as cosmetic.</td>
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<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
</tr>
<tr>
<td><strong>Brow Ptosis Repair</strong></td>
<td></td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)</td>
</tr>
<tr>
<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarsal) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarsal) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67908</td>
<td>Repair of blepharoptosis; conjunctivo-tarsal-Muller's muscle-levator resection (eg, Fasanella-Servat type)</td>
</tr>
</tbody>
</table>

Note: The following ICD-9-CM codes are the only covered ICD-9-CM codes that support medical necessity for CPT codes 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906 and 67908:

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>333.81</td>
<td>Blepharospasm</td>
</tr>
<tr>
<td>374.00</td>
<td>Entropion unspecified</td>
</tr>
<tr>
<td>374.01</td>
<td>Senile entropion</td>
</tr>
<tr>
<td>374.02</td>
<td>Mechanical entropion</td>
</tr>
<tr>
<td>374.03</td>
<td>Spastic entropion</td>
</tr>
<tr>
<td>374.04</td>
<td>Cicatricial entropion</td>
</tr>
<tr>
<td>374.05</td>
<td>Trichiasis of eyelid without entropion</td>
</tr>
<tr>
<td>374.10</td>
<td>Ectropion unspecified</td>
</tr>
<tr>
<td>374.11</td>
<td>Senile ectropion</td>
</tr>
<tr>
<td>374.12</td>
<td>Mechanical ectropion</td>
</tr>
<tr>
<td>374.13</td>
<td>Spastic ectropion</td>
</tr>
<tr>
<td>374.14</td>
<td>Cicatricial ectropion</td>
</tr>
<tr>
<td>374.30</td>
<td>Ptosis of eyelid unspecified</td>
</tr>
<tr>
<td>374.31</td>
<td>Paralytic ptosis</td>
</tr>
<tr>
<td>374.32</td>
<td>Myogenic ptosis</td>
</tr>
<tr>
<td>374.33</td>
<td>Mechanical ptosis</td>
</tr>
<tr>
<td>374.34</td>
<td>Blepharochalasis</td>
</tr>
<tr>
<td>374.87</td>
<td>Dermatochalasis</td>
</tr>
<tr>
<td>743.61</td>
<td>Congenital ptosis of eyelid</td>
</tr>
<tr>
<td>V52.2</td>
<td>Fitting and adjustment of artificial eye</td>
</tr>
</tbody>
</table>
REFERENCES


Health Plan of Nevada Generic Evidence of Coverage, modified 2009.

Local Coverage Determination


Nelson, CC. Presentation at the 2003 American Academy of Facial Plastic and Reconstructive Surgery
annual meeting.


### PROTOCOL HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/24/2011</td>
<td>Corporate Medical Affairs Committee</td>
</tr>
<tr>
<td>11/2010</td>
<td></td>
</tr>
</tbody>
</table>

The foregoing Health Plan of Nevada/Sierra Health & Life Healthcare Operations protocol has been adopted from an existing UnitedHealthcare coverage determination guideline that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee.