BLEPHAROPLASTY, BLEPHAROPTOSIS AND BROW PTOSIS REPAIR

Guideline Number: CDG.002.03
Effective Date: August 1, 2014

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs), and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee’s specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COVERAGE RATIONALE

Plan Document Language

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group:

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee’s specific plan document to determine benefit coverage.
Indications for Coverage

Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to enrollee’s plan specific documents.

Criteria for a Coverage Determination that Surgery is Reconstructive and Medically Necessary

The following must be available when requested by UnitedHealthcare:

- Best corrected visual acuity in both eyes, all patients (except pediatrics).
- Eye exam (chief complaint, HPI)
- Color photograph(s) (eye level, frontal with patient looking straight ahead, light reflex visible and centered)
- Peripheral or superior visual fields automated, reliable (see Definitions), untaped/taped are preferable. Note the following:
  - In situations where computerized visual field testing is not available we will accept manual visual field testing.
  - In situations where visual field testing is not possible, see section below: “When Patient is Not Capable of Visual Field Testing”.

Note: The visual fields and color photograph(s) must be consistent.

If multiple procedures are requested the following criteria must be met:

1. All criteria for each individual procedure must be met; and
2. Visual field testing shows visual impairment which can’t be addressed by one procedure alone; and
3. Color photograph findings are consistent with visual field findings.

A. Upper eyelid blepharoplasty (CPT 15822 and 15823) is considered reconstructive and medically necessary when the following criteria are present:

1. Ptosis has been ruled out as the primary cause of visual field obstruction; and
2. The color photograph must show:
   - The extra skin, but not the lid margin, taped up to show it reverses the visual field obstruction; and/or
   - Lateral hooding present, and
3. The patient must have a Functional/Physical Impairment complaint directly related to an abnormality of the eyelid(s); and
4. Excess skin (dermatochalasis/blepharochalasis) touches the lashes; and
5. Automated peripheral or superior visual field testing, with the eyelids taped and untaped, showing improvement of 30% or more in number of points seen.
   - (In situations where computerized visual field testing is not available we will accept manual visual field testing.
   - In situations where visual field testing is not possible, see section below, “When Patient is Not Capable of Visual Field Testing”.

Note: Extended blepharoplasty may be indicated for blepharospasm (eyelids are forced shut) when the following two criteria are met:

1. Debilitating symptoms (e.g. pain); and
2. Conservative treatment has been tried and failed, or is contraindicated (e.g. Botox®)
B. Upper eyelid blepharoptosis repair (CPT 67901–67909) is considered reconstructive and medically necessary when the following criteria are present:

1. The patient must have a Functional/Physical Impairment complaint directly related to the position of the eyelid(s); and
2. Other causes of ptosis are ruled out (e.g. recent Botox injections, myasthenia gravis when applicable); and
3. Eyelid droop (upper eyelid ptosis) and an MRD-1 of 2.0 mm or less; and
4. The MRD is documented in color photographs with patient looking straight ahead and light reflex centered on the pupil; and
5. Automated peripheral or superior visual field testing, with the eyelids taped and untaped, showing improvement of 30% or more improvement in the number of points seen.

- In situations where computerized visual field testing is not available we will accept manual visual field testing.
- In situations where visual field testing is not possible, see section below, “When Patient is Not Capable of Visual Field Testing”.

**Note:** For children under age 10 years, ptosis repair is covered to prevent amblyopia. Visual field testing is not required, but, a color photograph is required.

C. Brow ptosis (CPT 67900) is considered reconstructive and medically necessary when the following criteria are present:

1. Other causes have been eliminated as the primary cause for the visual field obstruction (e.g. Botox® treatments within the past six (6) months); and
2. Patient must have a functional complaint related to brow ptosis. Brow ptosis must be documented in two color photographs. One showing the eyebrow below the bony superior orbital rim, and a second photograph with the brow taped up that eliminates the visual field defect; and

- Automated peripheral and superior visual field testing, with differential taping (eyebrow and eyebrow + eyelid) showing 30% or more improvement in total number of points seen with the eyebrow taped up. In situations where computerized visual field testing is not available we will accept manual visual field testing.
- In situations where visual field testing is not possible, see section below, “When Patient is Not Capable of Visual Field Testing”.

D. Eyelid surgery with an anophthalmic socket (has no eyeball) is considered reconstructive and medically necessary when both of the following criteria are present:

1. Patient has an anophthalmic condition; and
2. Patient is experiencing difficulties fitting or wearing an ocular prosthesis.

E. Lower eyelid blepharoplasty (CPT 15820 and 15821) is usually cosmetic, however, is considered reconstructive and medically necessary only when all of the following criteria are present:

1. There is documented facial nerve damage; and
2. Color photograph documents the pathology; and
3. Patient is unable to close the eye due to the lower lid dysfunction; and
4. Functional impairment including both of the following:
   i. Documented uncontrolled tearing or irritation; and
   ii. Conservative treatments tried and failed.
F. Ectropion (eyelid turned outward) (CPT 67914 through 67917) or punctal eversion is considered reconstructive and medically necessary when all of the following criteria are present:
   1. Color photograph documents the pathology; and
   2. Conservative treatments have been tried and failed; and
   3. Corneal or conjunctival injury with both of the following criteria:
      i. Subjective symptoms include either:
         a. Pain or discomfort; or
         b. Excess tearing; and
      ii. Any one of the following:
         c. Exposure keratitis; and/or
         d. Keratoconjunctivitis; and/or
         e. Corneal ulcer

G. Entropion (eyelid turned inward) (CPT 67921-67924) is considered reconstructive and medically necessary when all of the following criteria are present:
   1. Color photograph must document the following:
      i. Lid turned inward; and
      ii. At least one of the following:
         a. Trichiasis; or
         b. Irritation of cornea or conjunctiva; and
   2. Conservative treatments have been tried and failed; and
   3. Subjective symptoms including either of the following:
      i. Excessive tearing; or
      ii. Pain or discomfort

H. Lid Retraction Surgery (CPT 67911) Lid retraction surgery is considered reconstructive and medically necessary when all of the following criteria are present:
   1. Other causes have been eliminated as the reason for the lid retraction such as use of dilating eye drops, glaucoma medications; and
   2. Color photograph documents the pathology; and
   3. There is functional impairment (such as 'dry eyes', pain/discomfort, tearing, blurred vision); and
   4. Tried and failed conservative treatments; and
   5. In cases of thyroid eye disease two or more Hertel measurements at least 6 months apart with the same base measurements are unchanged.

I. Canthoplasty/Canthopexy (CPT 21280, 21282, 67950, 67961, 67966) is considered reconstructive and medically necessary when all of the following criteria are present:
   1. Functional impairment; and
   2. Conservative treatments have been tried and failed; and
   3. Color photograph documents the pathology; and
   4. Simple repair of ectropion or entropion will not correct condition; and
   5. At least one of the following patient complaints is present:
      i. Epiphora (excess tearing) not resolved by conservative measures; or
      ii. Corneal dryness unresponsive to lubricants; or
      iii. Corneal ulcer

When Patient Is Not Capable of Visual Field Testing:
Visual field testing is not required when the patient is not capable of performing a visual field test. The following are some examples:
- If the patient is a child 12 years old or under.
- If the patient has intellectual disabilities (previously known as mental retardation) or some other severe neurologic disease.

California Only:
This is the mandated language for **Reconstructive Procedures** - Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or create a normal appearance, to the extent possible.

**Coverage Limitations and Exclusions**
Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to enrollee’s plan specific documents.

Cosmetic Procedures are excluded from coverage:

A. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

B. Any procedure that does not meet the reconstructive criteria above in the Indications for Coverage section.

**DEFINITIONS**

When applicable, please refer to the enrollee-specific plan document for definitions.

**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. (2011 Generic COC)

**Congenital Anomaly (For California Only)**: A physical developmental defect that is present at birth

**Cosmetic Procedures**: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by UHC. (2011 Generic COC)

**Cosmetic Procedures (For California Only)**: Procedures or services are performed to alter or reshape normal structures of the body in order to improve the Covered Person’s appearance

**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.

**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. (Note: the “-1” in MRD-1 refers to the upper lid and not the measurement in millimeters.)

**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. (Note: the “-2” in MRD-2 refers to the lower lid and not the measurement in millimeters.)
Reconstructive Procedures: Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. (2011 Generic COC)

Reconstructive Procedures (For California Only): Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible.

Reliability (Visual Fields): Fixation loss is less than or equal to 33 %.

APPLICABLE CODES

The Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other policies and coverage determination guidelines may apply.

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<thead>
<tr>
<th>Limited to specific procedure codes?</th>
<th>YES</th>
<th>NO</th>
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<table>
<thead>
<tr>
<th>CPT® Procedure Code</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Blepharoplasty (Lower Eyelid)</strong></td>
<td></td>
</tr>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid;</td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid, with extensive herniated fat pad</td>
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<tr>
<td><strong>Blepharoplasty (Upper Eyelid)</strong></td>
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<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid;</td>
</tr>
<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 (supraciliary, mid-forehead or coronal approach)</td>
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<tr>
<td><strong>Upper Eyelid Blepharoptosis Repair</strong></td>
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<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)</td>
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<tr>
<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
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<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach</td>
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<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
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<td>CPT® Procedure Code</td>
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<tr>
<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
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<tr>
<td>67908</td>
<td>Repair of blepharoptosis; conjunctivo-tarso-muller’s muscle-levator resection (eg, fasanella-servat type)</td>
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<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
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<td><strong>Lid Retraction</strong></td>
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<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
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<tr>
<td></td>
<td><strong>Ectropion</strong></td>
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<tr>
<td>67914</td>
<td>Repair of ectropion; suture</td>
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<td>67915</td>
<td>Repair of ectropion; thermocauterization</td>
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<tr>
<td>67916</td>
<td>Repair of ectropion; excision tarsal wedge</td>
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<tr>
<td>67917</td>
<td>Repair of ectropion; extensive (eg, tarsal strip operations)</td>
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<td></td>
<td><strong>Entropion</strong></td>
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<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
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<tr>
<td>67922</td>
<td>Repair of entropion; thermocauterization</td>
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<tr>
<td>67923</td>
<td>Repair of entropion; excision tarsal wedge</td>
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<tr>
<td>67924</td>
<td>Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)</td>
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<td><strong>Canthus Repair and Lid Repair</strong></td>
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<tr>
<td>21280</td>
<td>Medial canthopexy (separate procedure)</td>
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<tr>
<td>21282</td>
<td>Lateral canthopexy</td>
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<tr>
<td>67950</td>
<td>Canthoplasty (reconstruction of canthus)</td>
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<tr>
<td>67961</td>
<td>Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to 1/4 of lid margin</td>
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<tr>
<td>67966</td>
<td>Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over 1/4 of lid margin</td>
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**Limited to specific diagnosis codes?**
- **YES**
- **NO**

**Limited to place of service (POS)?**
- **YES**
- **NO**

**Limited to specific provider type?**
- **YES**
- **NO**

**Limited to specific revenue codes?**
- **YES**
- **NO**

**REFERENCES**


**GUIDELINE HISTORY/REVISION INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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| 08/01/2014 | • Revised coverage rationale/indications for coverage for services requiring automated visual field testing; added language to indicate manual visual field testing will be accepted in situations where computerized visual field testing is not available  
• Archived previous policy version CDG.002.02 |