

Blepharoptosis Repair

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<u>Coverage Policy</u>	Surgical 211
<u>Version</u>	3

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Blepharoptosis Repair.

- Visual Fields submitted using manual or non-automated methodology are not suitable for medical necessity determinations.

Description & Definitions:

Blepharoptosis repair is the surgical procedure to correct drooping of the upper eyelids.

Procedures that correct the anatomy without improving or restoring physiologic function are considered Cosmetic Procedures.

Reconstructive: Blepharoptosis repair procedures which are intended to correct a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect are considered reconstructive in nature.

Criteria:

Blepharoptosis repair is considered medically necessary for **1 or more of the following**:

- **Adult with 1 or more of the following:**
 - Documentation of **ALL of the following**:
 - Ptosis of lid or dermatochalasis as documented by **1 or more of the following**:
 - Congenital ptosis with amblyopia
 - Margin reflex distance 1 (MRD1) less than or equal to 2 mm in central gaze
 - Margin reflex distance 1 (MRD1) less than or equal to 2 mm in down gaze with impairment of reading
 - Individual complains of interference with vision or visual field-related activities (e.g., difficulty reading or driving due to eyelid position)

- Upper eyelid margin is less than 2.5 mm from the corneal light reflex
- Eye level photographs documenting the abnormal lid position
- Visual field testing performed using automated methodology demonstrating **ALL of the following**:
 - Superior visual field reduced to 25 degrees or less as measured from the central fixation point
 - Taping of the redundant eyelid tissue results in a correction of the defect and restoration of normal central visual field
 - Photographs demonstrate excess tissue is at or below the superior curvature of the pupil and is corrected with taping
 - Visual fields demonstrate that the corresponding 25 degrees or more of impairment is improved in repeat testing of at least 50% with taping excess skin
- Facial nerve palsy with marked periorbital laxity and redundancy
- Thyroid disease not responsive to medical management
- **Child with ALL of the following**:
 - Child is 9 years of age or younger
 - Blepharoptosis repair to relieve obstruction of central vision severe enough to produce occlusion amblyopia
- **Individual with anophthalmic socket (no eyeball) with ALL of the following**:
 - Provider documents anophthalmic condition
 - Provider documents individual experiencing difficulties wearing an ocular prosthesis caused by eyelid mal-position
 - High quality photographs documenting the eyelid mal-position submitted

Blepharoptosis repair is considered **not medically necessary** for any use other than those indicated in clinical criteria.

Coding:

Medically necessary with criteria:

Coding	Description
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	Reduction of overcorrection of ptosis
67304	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

Considered Not Medically Necessary:

Coding	Description
	None

Document History:

Revised Dates:

- 2020: June
- 2019: November
- 2016: January, February
- 2015: May, October
- 2013: June
- 2009: June
- 2008: August
- 2005: September
- 2003: October

Reviewed Dates:

- 2023: April
- 2022: April
- 2021: May
- 2018: July, November
- 2017: November
- 2016: June
- 2015: June
- 2014: June
- 2012: June
- 2011: June
- 2010: June
- 2004: October

Effective Date:

- October 1991

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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(2023). Retrieved Feb 27, 2023, from HAYES:

<https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Blepharoplasty%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%2522:%2>

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Blepharoptosis Repair, SHP Surgical 13, eyelid margin, blepharospasm, Visual field testing, vision, Facial nerve palsy, periorbital laxity, thyroid disease, eyeball, anophthalmic socket, eyelid dermatitis, prosthesis, Surgical 211