Sentara Health Plans

Medicaid

Eyelid Procedures and Brow Lift, Surgical 13

Table of Content

Description & Definitions
Criteria
Document History
Coding
Policy Approach and Special Notes
References
Keywords

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Coverage Policy	Surgical 13
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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 by 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.*.

Description & Definitions:

Blepharoplasty is the surgical removal of redundant skin, muscle, and fatty tissue from the upper and/or lower eyelids.

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

Brow lift is a surgical procedure to lift the eyebrows by removing excessive or loose skin from the forehead.

Arthroplasty/ canthopexy is surgical repair by canthal structures for drooping of the corners of the eyelids.

Ectropion is out-turning of the eyelids.

Entropion is inward turning of eyelids.

Lid Retraction is the inability to fully close eyelids.

Reconstructive Procedures 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.

***NOTE**: Procedures that correct the anatomy without improving or restoring physiologic function are considered Cosmetic Procedures

Criteria:

Eyelid Procedures and Brow Lift are medically necessary for **1 or more** of the following:

- **UPPER eyelid Blepharoplasty** (15822, 15823) is covered for **1 or more** of the following:
    - Blepharochalasis, dermatochalasis or pseudoptosis with **1 or more** of the following:
        - Visual field defects with **ALL** of the following:
            - Clear photograph documentation at eye level with the individual looking straight ahead and **1 or more** of the following
                - Redundant skin overhanging the upper eyelid margin and resting on eyelashes
                - Significant dermatitis on the upper eyelid caused by the excess tissue
            - Visual Field loss or Testing with **ALL** of the following:
                - upper visual field loss of at least 20 degrees
                - 30% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelid AND
        - Difficulty tolerating a prosthesis in an anophthalmic socket; or
        - Repair of a functional defect caused by 1 or more of the following:
            - trauma, tumor, surgery, or Congenital defect; or
            - Periorbital sequelae of thyroid disease; or
            - Nerve palsy; OR
            - Blepharospasm
            - Exposure keratitis due to **1 or more** of the following
                - Eyelid laxity
                - Inability to properly close eye due to Bell palsy or other disorder
    - Occlusion amblyopia with **ALL** of the following:
        - Child is 9 years of age or younger
        - Severe obstruction of central vision as determined by a physician.
- **LOWER eyelid blepharoplasty** (15820, 15821) is considered medically necessary for **1 or more** of the following indications when there is a functional visual impairment as documented by preoperative frontal photographs:
    - Lower eyelid edema due to a metabolic or inflammatory disorder when the edema is causing a persistent visual impairment (e.g., secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome) and is unresponsive to conservative medical management
    - Corneal and/or conjunctival injury or disease due to entropion or epiblepharon
    - Lid laxity with uncontrolled tearing and/or irritation as documented by history
- **LOWER or UPPER eyelid ectropion or entropion repair** (67914—67924) is considered medically necessary for **1 or MORE** of the following:
    - Corneal and/or conjunctival injury
    - Disease due to ectropion, entropion or trichiasis
- **UPPER eyelid ptosis (blepharoptosis) repair** (67901—67908) is considered medically necessary for **1 or more** of the following:
    - **Adult** with **All** of the following:
        - Visual Field loss or Testing with **1 or more** of the following:
            - upper visual field loss of at least 20 degrees
            - 30% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelidThe margin reflex distance (MRD) between the pupillary light reflex and the upper eyelid skin edge is less than or equal to 2.0 mm;
        - Eye level photographs documenting the abnormal lid position
        - Documented complaints of interference with vision or visual field-related activities such as:
            - Difficulty reading; or
            - Driving due to eyelid position
    - Occlusion amblyopia with **ALL** of the following:
        - Child is 9 years of age or younger
        - Severe obstruction of central vision as determined by a physician.
- **Brow Lift** (67900) is considered medically necessary for **ALL** of the following:
    - Brow ptosis is causing functional visual impairment confirmed by photographs demonstrating that the eyebrow is below the supraorbital rim
    - Individual complains of interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through eyelashes or seeing upper eyelid skin
- **Canthoplasty/Canthopexy** (21280, 21282, 67950, 67961, 67966) is considered medically necessary for **ALL** of the following:

    - Functional impairment; and/or symptomatic eyes of **1 or more** of the following:
        - Redness, irritation, dry eyes, pain/discomfort, tearing, blurred vision
        - Cornea damage (keratopathy).
        - Ectropion.
        - Entropion.
        - Lagophthalmos.
        - Trauma.
    - Failed or contraindications to medical management (medications, treatment of disease and/or therapeutic injections)
- **Lid retraction surgery** (67911) is considered medically necessary for **ALL** of the following:
    - Functional impairment; and symptomatic eyes (e.g., redness and irritation, dry eyes, pain/discomfort, tearing, blurred vision)
    - Margin reflex distance 1 (MRD1) is greater than 5.3 mm
    - Unstable measurement of upper eyelid retraction < 6 months
    - Failed or contraindications to medical management (medications, treatment of disease and/or therapeutic injections)
- A **combination** of **ANY** of the above procedures is considered medically necessary when the medical necessity criteria for each procedure are met and **ALL** of the following additional criteria are met:
    - Visual field testing demonstrates visual impairment that cannot be addressed by one procedure alone
    - Lateral and full-face photographs with attempts at 1) brow elevation and, 2) upward gaze (i.e., with the brow relaxed) support the request
    - Findings consistent with visual field loss documented on visual field testing

Eyelid Procedures and Brow Lift is considered **not medically necessary** for any use other than those indicated in clinical criteria, including but not limited to:

- Non-surgical eyelid weights

Document History:

Revised Dates:

- 2026: June – Implementation date of October 1, 2026. Criteria updated.
- 2025: October – Coding updated. Implementation date of February 1, 2026.
- 2025: January – Procedure codes updated to align with authorization changes effective 1/1/2025. Additional criteria for procedure codes included.
- 2024: August
- 2023: July
- 2022: April
- 2020: June
- 2019: November
- 2016: January, February
- 2015: May, October
- 2013: June
- 2009: June
- 2008: August
- 2005: September
- 2003: October

Reviewed Dates:

- 2026: February – Implementation date of June 1, 2026. Annual review and housekeeping.
- 2023: April
- 2021: May
- 2018: July, November
- 2017: November
- 2016: June
- 2015: June
- 2014: June
- 2012: June

- 2011: June
- 2010: June
- 2004: October

Origination Date: October 1991

Coding:

Medically necessary with criteria:

Coding	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 weighting down lid
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
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	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fasciarepairs operation)

Considered Not Medically Necessary:

Coding	Description
	None

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage
  - Visual Fields submitted using manual or non-automated methodology are not suitable for medical necessity determinations.
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.

- Authorization requirements
  - Pre-certification by the Plan is required.
  - **Please refer to Prior Authorization List for most up to date requirement** **Search PAL List: Sentara Health Plans**
  - Any requested repairs of the non-affected eye to maintain good vision must be approved by an Sentara Health Plan Medical Director.
- 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 by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22) Final.pdf
  - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

References used include but are not limited to the following: 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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Keywords:

Blepharoplasty, Surgical 13, eyelid margin, blepharospasm, Visual field testing, vision, Facial nerve palsy, periorbital laxity, thyroid disease, eyeball, anophthalmic socket, eyelid dermatitis, prosthesis, SHP Surgical 211 (archived), Herring's law, SHP Surgical 212 (archived), Blepharoptosis, and Brow Lift