SHP Blepharoptosis Repair

AUTH: SHP Surgical 211 v3 (AC)

MCG Health
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Link to Codes

Coverage

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See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.

Application to Products

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- Policy is applicable to all products.

Authorization Requirements

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Pre-certification by the Plan is required.

Any requested repairs of the non-affected eye to maintain good vision must be approved by an Optima medical director.

Description of Item or Service

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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.

Exceptions and Limitations

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There is insufficient scientific evidence to support the medical necessity of blepharoptosis repair for uses other than those listed in the clinical indications for procedure section.

Clinical Indications for Procedure

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- Blepharoptosis repair is considered medically necessary for **1 or more** of the following:
  - Individual has Optima Commercial Plan or Optima Virginia Medicaid Plan with **1 or more** of the following :
    - Individual is an 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 complaints 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
    - Individual is a 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 anaopthalmic condition
      - Provider documents individual experiencing difficulties wearing an ocular prosthesis caused by eyelid mal-position
      - High quality photographs documenting the eyelid mal-position submitted
  - Individual has Optima Medicare Plan with **ALL** of the following:
    - Individual's upper lid position or overhanging skin is sufficiently low to produce functional deficit related to visual field impairment or brow fatigue
    - Surgical ptosis repair as indicated by **ALL** of the following:
      - Persistent pseudoptosis (false ptosis), where eyelid margin is usually in appropriate anatomic position with respect to the eyeball and visual axis but amount of excessive skin from dermatochalasis or blepharochalasis is so great as to overhang eyelid margin
      - Absence of other causes of pseudoptosis, such as hypotropia and globe malposition
    - Individual has a functional deficit or disturbance secondary to eyelid and/or brow abnormalities as documented by **1 or more** of the following:

- Interference with vision or visual field (e.g., difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue) that impacts an activity of daily living (such as difficulty reading or driving), looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue
- Difficulty fitting spectacles
- Debilitating eyelid irritation
- Difficulty fitting or wearing a prosthesis when associated with an anophthalmic, microphthalmic, or enophthalmic socket. Photographic documentation demonstrating abnormalities as they relate to the abnormal upper and/or lower eyelid position related to prosthesis wear are required
- Blepharospasm: In such cases a description of the debility and a history of failed prior treatment is required

▪ Documentation shows that the eye being considered for surgery has physical signs consistent with the functional deficit or abnormality as documented by **ALL** of the following:
- A 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 (NOT to any overhanging skin that may be present) with the brows relaxed
- If applicable, the presence of Hering's effect defending bilateral surgery when only the more ptotic eye clearly meets the margin reflex distance (MRD) criteria in that Hering's law is one of equal innervation to both upper eyelids. If lifting the more ptotic lid with tape or by instillation of phenylephrine drops into the superior fornix causes the less ptotic lid to drop downward and meet the strict criteria, the less ptotic lid is also a candidate for surgical correction.

▪ Photographic documentation with **ALL** of the following:
- Color photographs
- The “physical signs” must be clearly represented in photographs of the structures of interest and the photographs must be of sufficient size and detail as to make those structures easily recognizable. The patient’s head must be parallel to the camera and not tilted, so as not to distort the appearance of any relevant finding (e.g., a downward head tilt might artificially reduce the apparent measurement of a margin reflex distance (MRD)
- Photographs must be identified with the individual’s name and the date
- Photographs must have **1 or more** of the following:
  - Photographs of both eyelids in the frontal (straight-ahead) position should demonstrate the margin reflex distance criteria. If the eyelid obstructs the pupil, there is a clear-cut indication for surgery. (For reference, the colored part of the eye is about 11 mm in diameter, so the distance between the light reflex and the lid would need to be about one fifth that distance or less for the MRD to be 2.0 mm or less).
  - In the special case of documenting the need for bilateral surgery because of Hering’s law, two photos are needed of **ALL** of the following:
    - One photo showing both eyes of the patient at rest demonstrating the margin reflex distance criterion in the more ptotic eye
    - Another photo showing both eyes of the patient with the more ptotic eyelid raised to a height restoring a normal visual field, resulting in increased ptosis (meeting the above margin reflex distance standard) in the less ptotic eye.

Document History

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

Coding Information

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- CPT/HCPCS codes covered if policy criteria is met:
  - CPT 67901 - Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
  - CPT 67902 - Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling(includes obtaining fascia)
  - CPT 67903 - Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
  - CPT 67904 - Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
  - CPT 67906 - Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
  - CPT 67908 - Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg,Fasanella-Servat type)
  - CPT 67909 - Reduction of overcorrection of ptosis
- CPT/HCPCS codes considered not medically necessary per this Policy:
  - None

References

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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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Local Coverage Determination (LCD) Blepharoplasty, Eyelid Surgery, and Brow Lift - L34411. (2021, May 20). Retrieved Apr 6, 2022, from CMS LCD: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34411&ver=46&keyword=Blepharoplasty&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&b

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Ptosis - Approach to the Patient. (2021, Nov 30). Retrieved Apr 7, 2022, from DynaMed: https://www.dynamed.com/approach-to/ptosis-approach-to-the-patient

White Paper on Functional Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair. (2015, Jan). Retrieved Apr 7, 2022, from American Society of Ophthalmic Plastic & Reconstructive Surgery (ASOPRS): https://asoprs.memberclicks.net/assets/docs/1%20-%20FINAL%20ASOPRS%20White%20Paper%20January%202015.pdf

Codes

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CPT® : 67901, 67902, 67903, 67904, 67906, 67908, 67909

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