JOHNS HOPKINS HEALTHCARE

Medical Policy: Blepharoplasty, Blepharoptosis Repair and Brow Lift
Department: Health Services
Lines of Business: EHP, USFHP, PPMCO, ADVANTAGE MD

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ACTION:
☐ New Policy
☒ Revising Policy Number: CMS02.07
☐ Superseding Policy Number
☐ Archiving Policy Number
☐ Retiring Policy Number

Effective Date: 02/10/2005
Review Dates: 10/22/03, 10/22/04, 10/21/05, 05/30/06, 10/13/06, 03/03/08, 03/02/09, 06/04/10, 08/23/11, 03/07/14, 06/06/14, 06/03/16, 05/15/18

Johns Hopkins HealthCare LLC (JHHC) provides a full spectrum of health care products and services for Employer Health Programs, Priority Partners, Advantage MD, and US Family Health Plan. Each line of business possesses its own unique contract and guidelines which, for benefit and payment purposes, should be consulted to know what benefits are available for reimbursement.

Specific contract benefits, guidelines or policies supersede the information outlined in this policy.

POLICY:


For Advantage MD, see Medicare Coverage Database:
Local Coverage Determination (LCD): Surgery: Blepharoplasty (L35004)

I. When benefits are provided under the member’s contract, JHHC considers upper eyelid blepharoplasty or blepharoptosis repair medically necessary for prevention of amblyopia in children less than or equal to age nine (9) with congenital ptosis resulting in obstruction of central vision.

II. When benefits are provided under the member’s contract, JHHC considers upper eyelid blepharoplasty or blepharoptosis repair medically necessary for treatment of the following medical conditions:
   A. Difficulty tolerating a prosthesis in an anophthalmic socket
   B. Repair of a functional defect caused by trauma, tumor or surgery
   C. Periorbital sequelae of thyroid disease or nerve palsy
   D. Epiphora due to ectropion and/or punctal eversion
   E. Painful blepharospasm unresponsive to medical management

III. When benefits are provided under the member’s contract, JHHC considers upper eyelid blepharoplasty or blepharoptosis repair medically necessary in individuals aged ten (10) or older to relieve obstruction of central vision when BOTH of the following criteria are met:
   A. Upper visual field loss of 20 degrees or 30% that is corrected with taping as documented on formal visual field testing, AND;
   B. Pre-operative photographs demonstrating at least ONE of the following:
1. The upper eyelid margin is within 2.5mm (1/4 of the diameter of the visible iris) of the corneal light reflex (MRD ≤ 2.5mm), with the patient in primary gaze, OR;
2. The upper eyelid skin rests on the eyelashes, OR;
3. The upper eyelid indicates the presence of dermatitis, OR;
4. The brow position is below the superior orbital rim.

IV. When benefits are provided under the member’s contract, JHHC considers blepharoplasty or blepharoptosis repair medically necessary for treatment of ANY of the following conditions documented in the medical record:
   A. Ectropion (eyelid turned outward), OR;
   B. Entropion (eyelid turned inward), OR;
   C. Trichiasis (inward misdirection of eyelashes caused by entropion), OR;
   D. Corneal exposure

V. When benefits are provided under the member’s contract, JHHC considers Brow Lift medically necessary when ALL of the following are met:
   A. Functional visual impairment is documented in the medical record, AND;
   B. Photographs demonstrate the eyebrow is below the supraorbital ridge, AND;
   C. Visual impairment cannot be corrected by upper lid blepharoplasty as documented in III.A. above.

VI. Unless specific benefits are provided under the member’s contract, JHHC considers all other types of blepharoplasty or blepharoptosis repair and brow lifts not medically necessary.

BACKGROUND:

Upper lid blepharoplasty is a surgical procedure performed on the upper lid to remove or repair excess tissue that obstructs the field of vision. Supratarsal fixation is fixation of the orbicularis muscle to the levator muscle and may be included in the blepharoplasty. Ptosis is drooping of the eyelid. Blepharoplasty is considered medically necessary when significant impairment of vision is medically documented. Otherwise, it is considered cosmetic.

Other surgeries of the eyelid due to 7th nerve palsy, lid retraction, entropion, brow ptosis, pathological lower lid fat herniation and other lid abnormalities or malposition may also be medically necessary if they cause obstruction to the field of vision, difficulty closing the lid over the eyeball, or difficulty fitting a prosthesis, or interfere with the use of eyeglasses.
CODING INFORMATION:

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage and referral requirements. All inpatient admissions require pre-authorization.

Pre-Authorization Required

Compliance with the provision in this policy may be monitored and addressed through post-payment data analysis and/or medical review audits

<table>
<thead>
<tr>
<th>Employer Health Programs (EHP) refer to specific Summary Plan Description (SPD). If there is no criteria in the SPD, apply the Medical Policy criteria.</th>
<th>Priority Partners (PPMCO) refer to COMAR guidelines and PPMCO SPD then apply the Medical Policy criteria</th>
<th>US Family Health Plan (USFHP), TRICARE Medical Policy supersedes JHHC Medical Policy. If there is no Policy in TRICARE, apply the Medical Policy Criteria</th>
<th>Advantage MD, LCD and NCD Medical Policy supersedes JHHC Medical Policy. If there is no LCD or NCD, apply the Medical Policy Criteria</th>
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<tbody>
<tr>
<td>CPT ® CODES</td>
<td>DESCRIPTION</td>
<td></td>
<td></td>
</tr>
<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>
<td></td>
<td></td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid;</td>
<td></td>
<td></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>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
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<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., 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; (tarsal) levator resection or advancement, internal approach</td>
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<td></td>
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<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarsal) levator resection or advancement, external approach</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 (e.g., Fasanella-Servat type)</td>
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Department: Health Services

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<table>
<thead>
<tr>
<th>ICD10 CODES</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>G24.5</td>
<td>Blepharospasm [unresponsive to medical management]</td>
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<tr>
<td>H02.001-H02.059</td>
<td>Entropion and Trichiasis of eyelid</td>
</tr>
<tr>
<td>H02.101-H02.109</td>
<td>Ectropion of eyelid</td>
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<tr>
<td>H02.401-H02.439</td>
<td>Ptosis of the eyelid {causing functional visional impairment}</td>
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<tr>
<td>H04.201-H04.219</td>
<td>Epiphora unspecified as to cause and due excess lacrimation</td>
</tr>
<tr>
<td>H05.89</td>
<td>Other disorders of orbit [endocrine exophthalmos]</td>
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<tr>
<td>H16</td>
<td>Keratitis</td>
</tr>
<tr>
<td>H49.0-H49.23</td>
<td>Third [oculomotor] nerve palsy</td>
</tr>
<tr>
<td>S00.10xA-S00.12xS</td>
<td>Contusion of unspecified eyelid and periocular area</td>
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<tr>
<td>S01.10A-S01.149S</td>
<td>Unspecified open wound, laceration, eyelid and periocular area, Puncture wound without/with foreign body of eyelid and periocular area</td>
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<tr>
<td>T26.00xA-T26.52xS</td>
<td>Burn and corrosion confined to eye and adnexa</td>
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<tr>
<td>T85.390A-T85.391S</td>
<td>Other mechanical complication of other ocular prosthetic devices, implants and grafts</td>
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<tr>
<td>Q10.0</td>
<td>Congenital ptosis</td>
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<tr>
<td>Q10.1-Q10.3</td>
<td>Congenital ectropion, entropion and other congenital malformations of eyelids</td>
</tr>
</tbody>
</table>
REFERENCE STATEMENT:

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins HealthCare LLC (JHHC) Medical Policy Team during the development and implementation of this medical policy. Per NCQA standards, the Medical Policy Team will continue to monitor and review any newly published clinical evidence and adjust the references below accordingly if deemed necessary.

REFERENCES:


