Regence

Blepharoplasty, Eyelid Surgery, and Brow Lift

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Blepharoplasty is a surgical procedure performed on the upper and/or lower eyelids to remove or repair excess tissue that obstructs the field of vision. Blepharoptosis repair involves repair of drooping of the eyelid and can include shortening or advancement of the elevator muscle of the eyelid. These procedures may also be performed for cosmetic purposes in the absence of visual field obstruction.

MEDICARE ADVANTAGE POLICY CRITERIA

Note: This policy only addresses blepharoplasty, eyelid surgery, and/or brow lift surgeries. Other possible cosmetic and reconstructive procedures may be addressed in Cosmetic and Reconstructive Procedures medical policy, Surgery, Policy No. M-SUR12

CMS Coverage Manuals*	None.
National Coverage Determinations (NCDs)*	None.
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	*For CPT codes 15820 and 15821, see the "Lower Eyelid Blepharoplasty" section of the LCD listed below.* For CPT codes **15822, 15823, and 67900-67904, 67906, 67908, 67909, 67999**: Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286) *(Companion article is A57191, which can be accessed directly from the LCD)* *For CPT codes 67911-67924, see notes regarding reconstructive surgery in the above LCD.* Scroll to the "Public Version(s)" section at the bottom of the LCD for links to prior versions if necessary.

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- Requested treatment, symptoms experienced, and history of condition being treated;
- Documentation regarding the functional impairment that has been caused by the condition and that requires repair; and
- Documentation of circumstances which caused the condition (e.g., congenital, postsurgery, accident, injury, etc., as applicable).

CROSS REFERENCES

Cosmetic and Reconstructive Procedures, Surgery, Policy No. M-SUR12

REFERENCES

None

CODING

Codes	Number	Description
CPT	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
	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
	67916	Repair of ectropion; excision tarsal wedge
	67917	Repair of ectropion; extensive (eg, tarsal strip operations)
	67923	Repair of entropion; excision tarsal wedge
	67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
	67950	Canthoplasty (reconstruction of canthus)
	67999	Unlisted procedure, eyelids
HCPCS	None	

IMPORTANT NOTE: Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.