Blepharoplasty, Blepharoptosis, and Brow Lift

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➲ Terms and Conditions

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Policy Summary

➲ See Purpose

Overview

Medicare does not cover cosmetic surgery or expenses incurred in connection with such surgery. Cosmetic surgery is defined by Medicare as: "any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose" (CMS Publication 100-2; Medicare Benefit Policy Manual, Chapter 16, Section 120). This policy guideline provides additional guidance on covered indications and limitations of coverage for blepharoplasty surgery.

Guidelines

The American Society of Plastic and Reconstructive Surgeons has published the following definitions:

- Blepharoplasty may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. It may be either reconstructive or cosmetic (aesthetic).
- Cosmetic Blepharoplasty: When blepharoplasty is performed to improve a patient's appearance in the absence of any signs or symptoms of functional abnormalities, the procedure is considered cosmetic.
- Reconstructive Blepharoplasty: When blepharoplasty is performed to correct visual impairment caused by drooping of the eyelids (ptosis); repair defects caused by trauma or tumor-ablative surgery (ectropion/entropion corneal exposure); treat periorbital sequelae of thyroid disease and nerve palsy; or relieve the painful symptoms of blepharospasm, the procedure should be considered reconstructive. This may involve rearrangement or excision of the structures with the eyelids and/or tissues of the cheek, forehead and nasal areas. Occasionally a graft of skin or other distant tissues is transplanted to replace deficient eyelid components.

Based upon the above definitions, surgery of the upper eyelids is reconstructive when it provides functional vision and/or visual field benefits or improves the functioning of a malformed or degenerated body member, but cosmetic when done to enhance aesthetic appearance. The goal of functional restorative surgery is to restore significant function to a structure that has been altered by trauma, infection, inflammation, degeneration (e.g., from aging), neoplasia, or developmental errors.

Upper blepharoplasty and/or repair of blepharoptosis may be considered functional in nature when excess upper eyelid tissue or the upper lid position produces functional complaints. Those functional complaints are usually related to visual field impairment in primary gaze and/or down gaze (e.g., reading position). The visual impairment is commonly related to a lower than normal position of the eyelid relative to the pupil and/or to excess skin that hangs over the edge of the eyelid. Upper blepharoplasty may also be indicated for chronic dermatitis due to redundant skin. Another indication for blepharoptosis surgery is for patients with an anophthalmic socket experiencing prosthesis difficulties. Brow ptosis (i.e., descent or droop of the eyebrows) can also produce or contribute to functional impairment. Either or both of these procedures may be required in some situations when a blepharoplasty would not result in a satisfactory functional repair. Similarly, surgery of the lower eyelids is reconstructive when poor eyelid tone (with or without entropion or ectropion) causes dysfunction of the “lacrimal pump,” lid retraction, and/or exposure keratoconjunctivitis that often results in epiphora (tearing).

The criteria below must be documented to demonstrate medical necessity.

- Documentation in the medical records must include patient complaints and findings secondary to eyelid or brow malposition such as:
  - Interference with vision or visual field, related to activities such as, difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue.
  - Chronic eyelid dermatitis due to redundant skin.
  - Difficulty wearing prosthesis, artificial eye.
  - Margin reflex distance (MRD) of 2.5 mm or less. (The margin reflex distance is a measurement from the corneal light reflex to the upper eyelid margin with the brows relaxed.)
  - If applicable, the presence of Herring's effect (related to equal innervation to both upper eyelids) defending bilateral surgery when only the more ptotic eye clearly meets the MRD criteria. 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.
- Photographs and/or Visual fields – Refer to the individual Local Coverage Determination (LCD) for the jurisdiction in which the procedure is performed.
- Repair of anatomical or pathological defects, including those caused by disease (including thyroid dysfunction and cranial nerve palsies), trauma, or tumor-ablative surgery. Surgery is performed to reconstruct the normal structure of the eyelid, using local or distant tissue. Reconstruction may be necessary to protect the eye and/or improve visual function. Conditions that may require blepharoplasty, ptosis repair, ectropion repair, or entropion repair are:
  - Ectropion and entropion.
  - Epiblepharon.
  - Post-traumatic defects of the eyelid.
  - Post-surgical defects after excision of neoplasm(s).
  - Lagophthalmos.
  - Congenital lagophthalmos.
  - Congenital ectropion, entropion.
  - Congenital ptosis.
  - Lid retraction or lag (due to horizontal lower eyelid laxity without ectropion or entropion, causing exposure keratopathy and/or epiphora; due to horizontal upper eyelid laxity, causing floppy eyelid syndrome; or due to orbital thyroid disease).
  - Chronic symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin.
- The medical record must contain documented patient complaints and pertinent examination findings to justify the medical necessity for functional, restorative procedures(s) for the treatment of any of the above conditions.
- Relief of eye symptoms associated with blepharospasm. Primary essential idiopathic blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated, a blepharoplasty combined with limited myectomy may be necessary. Patient complaints and relevant medical history (e.g., failure to respond to botulinum toxin therapy, botulinum toxin therapy is contraindicated, etc.) must be documented and available upon request.

When a noncovered cosmetic procedure is performed in the same operative session as a covered surgical procedure, benefits will be provided for the covered procedure only. For example, if blepharochalasis would be resolved sufficiently by brow ptosis repair alone, an upper lid blepharoplasty in addition would be considered cosmetic. Similarly, if a visual field deficit would be resolved sufficiently by upper lid blepharoplasty alone (for tissue hanging over the lid margin), a blepharoptosis repair in addition would be considered cosmetic.

Documentation Requirements

The patient medical records should be legible, contain the relevant history and physical findings conforming to the criteria stated in this policy. Every page of the medical record must include appropriate patient identification information. The submitted medical record must support the use of the selected ICD10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

Copies of the following must be made available on request:

- Pre-operative exam,
- Photographs and/or Visual fields with physician interpretation, when applicable, and
- Operative report.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
15820	Blepharoplasty, lower eyelid [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15822	Blepharoplasty, upper eyelid [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., 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 (e.g., Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (e.g., 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 (e.g., tarsal strip or capsulopalpebral fascia repairs operation)

Modifier	Description
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
50	Bilateral Procedure

Diagnosis Code
Blepharoplasty, Blepharoptosis, and Brow Lift : Diagnosis Code List ☐

Definitions

Blepharochalasis: Excess skin associated with chronic recurrent eyelid edema that physically stretches the skin.

Blepharoptosis: Drooping of the upper eyelid which relates to the position of the eyelid margin with respect to the eyeball and visual axis.

Brow Ptosis: Drooping of the eyebrows to such an extent that excess tissue is pushed into the upper eyelid. It is recognized that in some instances the brow ptosis may contribute to significant superior visual field loss. It may coexist with clinically significant dermatochalasis and/or lid ptosis.

Dermatochalasis: Excess skin with loss of elasticity that is usually the result of the aging process.

Horizontal Eyelid Laxity: Poor eyelid tone, usually a result of the aging process, that causes (1) lid retraction without frank ectropion formation but with corneal exposure and irritation (foreign body sensation) and (2) dysfunction of the eyelid "lacrimal pump," both of which result in symptomatic tearing (epiphora).

Pseudoptosis: "False ptosis," for the purposes of this policy, describes the specific circumstance when the eyelid margin is usually in an appropriate anatomic position with respect to the eyeball and visual axis but the amount of excessive skin from dermatochalasis or blepharochalasis is so great as to overhang the eyelid margin and create its own ptosis. Other causes of pseudoptosis, such as hypotropia and globe malposition, are managed differently and do not apply to this policy. Pseudoptosis resulting from insufficient posterior support of the eyelid, as in phthisis bulbi, microphthalmos, congenital or acquired anophthalmos, or enophthalmos is often correctable by prosthesis modification when a prosthesis is present, although persistent ptosis may be corrected by surgical ptosis repair.

Questions and Answers

1	**Q:**	Is prior notification required?
	A:	Please check UnitedHealthcareOnline for current status.

References

CMS National Coverage Determinations (NCDs)

NCD 140.9 Gender Dysphoria and Gender Reassignment Surgery

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L33944 Blepharoplasty	A56439 Billing and Coding: Blepharoplasty	CGS	KY, OH	KY, OH
L34028 Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow	A57025 Billing and Coding: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow	First Coast	FL, PR, VI	FL, PR, VI
L34194 Blepharoplasty, Eyelid Surgery, and Brow Lift	A57190 Billing and Coding: Blepharoplasty, Eyelid Surgery, and Brow Lift	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L36286 Blepharoplasty, Eyelid Surgery, and Brow Lift	A57191 Billing and Coding: Blepharoplasty, Eyelid Surgery, and Brow Lift	Noridian	AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY	AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY
L35004 Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow	A57618 Billing and Coding: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, TX, PA	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, TX, PA
L34411 Blepharoplasty, Eyelid Surgery, and Brow Lift	A56503 Billing and Coding: Blepharoplasty, Eyelid Surgery, and Brow Lift	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L34528 Blepharoplasty, Blepharoptosis and Brow Lift	A56908 Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift	WPS	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
N/A	A52837 Blepharoplasty – Medical Policy Article	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
N/A	A53793 Billing and Coding: Gender Reassignment Services for Gender Dysphoria	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
N/A	A56869 Billing and Coding: Use of Laterality Modifiers	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
N/A	A55797 Upper Eyelid and Brow Surgical Procedures **Retired 07/01/2022**	First Coast	FL, PR, VI	FL, PR, VI

CMS Benefit Policy Manual

Chapter 16; § 20 Services Not Reasonable and Necessary, § 120 Cosmetic Surgery

Other(s)

Social Security Act (Title XVIII) Standard References:

- § 1862 (a)(1)(A) Medically Reasonable & Necessary,
- § 1862(a)(10) Cosmetic Surgery

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
02/23/2024	**Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG028.11

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section above to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and

Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.