Medical Management Policy

**Service:** Blepharoplasty, Blepharoptosis Repair, Brow lift, and Related Procedures

*PUM 250-0004*

<table>
<thead>
<tr>
<th>Medical Policy Committee Approval</th>
<th>03/15/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date</td>
<td>07/01/19</td>
</tr>
<tr>
<td>Prior Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Disclaimer:** This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may or may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

**Description:**

Blepharoplasty surgery is performed to remove excessive skin, fat, or muscle of the eyelids. Brow ptosis surgery is performed to remove redundant brow tissue. Blepharoptosis repair is performed to correct weakness of the levator muscles of the eyelid. Canthoplasty surgery is performed on the medial canthus and or lateral canthus (the angle formed where the upper and lower eye lid meet at either side of the eye) to treat eyelid malposition. These procedures are performed for a variety of reasons, including: To treat functional impairment, repair injury, reconstruct to restore normal anatomy and eyelid function after surgery, trauma, or illness; or to improve appearance (cosmetic). Procedures done for cosmetic purposes are often exclusions of the health plan and not a covered benefit.

**Indications of Coverage:**

The following procedures are considered medically necessary when the indicated condition-specific criteria are met:

**Note:** If both blepharoplasty and blepharoptosis repair are requested, criteria must be met for both procedures and there must be demonstration of visual impairment which cannot be addressed by one procedure alone.

A. Difficulty with prosthesis in an anophthalmic socket- artificial eye (visual testing not needed) and both of the following:

1. Documentation that the difficulty wearing the prosthesis is caused by an eyelid malposition, AND

2. High quality photographs document the eyelid malposition.
B. Upper eyelid blepharoplasty, when ALL of the following are met:

1. Documentation of patient complaints and physical findings secondary to eyelid or brow malposition (such as interference with vision or visual field related to activities such as reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue and/or chronic eyelid dermatitis due to redundant skin)

2. Documentation of dermatochalasis/blepharochalasis

3. High quality photographs which demonstrate that the excess skin touches the eyelashes

4. At least 12 degrees or at least 24% superior visual field difference is demonstrated between visual field testing before and after taping of the eyelid

C. Upper eyelid blepharoptosis repair, when ALL of the following are met:

1. Documentation of interference with vision or visual field related to activities such as difficulty reading due to upper eyelid drooping

2. Documentation of upper eyelid ptosis (droop) and margin reflex distance (MRD) of 2.0 mm or less

3. High quality photographs demonstrate the MRD of 2.0 mm or less and the eyelid at or below the upper edge of the pupil

4. At least 12 degrees or at least 24% superior visual field difference demonstrated between visual field testing before and after taping of the eyelid

D. Brow Ptosis (“Brow lift”) surgery, when ALL of the following are met:

1. Documentation of visual complaints related to brow droop and objective findings of brow droop

2. High quality photographs with the brow at rest and with the brow elevated. The, “at rest” photograph must show that most of the eyebrow is below the superior orbital rim and is causing excess skin and/or drop of the upper eyelid. The brow elevated photo must show that the excess skin and/or upper eyelid margin are no longer obscuring the upper iris.

3. At least 12 degrees or at least 24% superior visual field difference is demonstrated between visual field testing before and after taping of the eyebrow.
E. Blepharoplasty or blepharoplasty in conjunction with myomectomy procedure for relief of eye symptoms associated with chronic blepharospasm (e.g. benign essential blepharospasm) is considered medically necessary when botulinum toxin-A injection has failed or is contraindicated. No photographs or visual impairment measurements are required to treat blepharospasm.

F. Blepharoplasty following myomectomy or other surgeries must meet criteria for functional impairment (e.g., Blepharoplasty criteria in section B above)

G. Lower lid blepharoplasty used to treat acute injury is considered medically necessary and does not require prior authorization.

H. Lower lid blepharoplasty and entropion/ectropion repair is considered medically necessary when there is documentation of any of the following:
   1. Ectropion with treatment of corneal ulcer or exposure keratitis
   2. Entropion with history of treatment of corneal abrasion
   3. Exposure keratitis due to inability to close the lid (e.g. periorbital sequelae of thyroid disease)
   4. Functional deficit caused by trauma, surgery (e.g. tumor removal), or injury

I. Canthoplasty is considered medically necessary to correct deformities caused by trauma or surgery (e.g., tumor removal)

Limitations of Coverage:

A. Review contract and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition/diagnosis other than is listed in the Indications of Coverage, It will be denied as experimental, investigational, and unproven to affect health outcomes.

C. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, it will be denied as not medically necessary.

D. Canthoplasty and Blepharoplasty of the lower lid are considered cosmetic for any indication not listed in the Indications of Coverage above.
Documentation Required:

- Office notes
- Visual field report
- Photographs

WPS / Arise Review History:

<table>
<thead>
<tr>
<th>Implemented</th>
<th>04/04/14, 04/17/15, 07/01/16, 07/01/17, 07/01/18, 07/01/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed</td>
<td>03/07/14, 03/13/15, 03/11/16, 03/17/17, 03/16/18, 03/15/19</td>
</tr>
<tr>
<td>Revised</td>
<td>03/07/14, 03/13/15, 03/11/16, 03/17/17, 03/16/18, 03/15/19</td>
</tr>
<tr>
<td>Developed</td>
<td></td>
</tr>
<tr>
<td>Medical Policy</td>
<td></td>
</tr>
<tr>
<td>Committee</td>
<td></td>
</tr>
<tr>
<td>Approval</td>
<td>03/07/14, 03/13/15, 03/11/16, 03/17/17, 03/16/18, 03/15/19</td>
</tr>
</tbody>
</table>

➢ Note: For review/revision history prior to 2014 see previous Medical Policy or Coverage Policy Bulletin

Approved by the Medical Director