KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Blepharoplasty

- Blepharoptosis
- Brow Lift

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286)
Local Coverage Article	Billing and Coding: Blepharoplasty, Eyelid Surgery, and Brow Lift (A57191)

For Non-Medicare Members

Blepharoplasty, blepharoptosis repair, or brow ptosis repair
Plastic Surgery and/or oculoplastics credentials are preferred for this facial surgery. The above procedures may be medically necessary when **ONE of** following are met:

I. **Upper eyelid reconstructive blepharoplasty** is considered medically necessary and NOT cosmetic when **ONE of the following** is met:

A. Blepharoplasty for the following diagnoses may be considered medically necessary for an affected upper or lower lid without meeting visual loss criteria:
   1. Trichiasis
   2. Ectropion
   3. Entropion
   4. Exposure keratitis
   5. Painful blepharospasm refractory to medical management

B. In the absence of one of the conditions listed above **unilateral or bilateral upper lid** may be considered medically necessary for reconstructive purposes when the operative eye **meets ALL of the following** criteria:
   1. Visual field less than 20° above central fixation – (untaped eye) OR limited to 10 to 15 degrees (untaped eye) laterally
   2. Frontal or lateral photograph demonstrates visual field limitation consistent with the visual field examination, AND
   3. Does not have unstable myasthenia gravis or a thyroid condition (No concerns about stability raised by Neurology for myasthenia gravis patients and normal thyroid lab if patient has pre-existing thyroid disease)
   4. **ALL of following** information must be submitted:
      - Visual fields, including physician interpretation
      - MRD1 (marginal reflex distance) measurement
      - Documentation of clinically decreased vision
      - Lateral and full-face photographs

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II. **Upper eyelid ptosis (blepharoptosis) repair** may be considered medically necessary for reconstructive purposes when the operative eye meets **ALL of the following** criteria:
   A. Documented complaints of interference with vision or visual field-related activities causing significant functional impairment (difficulty reading or driving due to eyelid position
   B. Photographs demonstrate the eyelid at or below the upper edge of the pupil
   C. Visual field less than 20° above central fixation
   D. MRD1 (marginal reflex distance from pupil center to upper eyelid) of 2.0mm or less
   E. Does not have unstable myasthenia gravis or a thyroid condition
   F. **ALL of the following** information must be submitted
      - Visual fields, including physician interpretation
      - MRD1 (marginal reflex distance) measurement
      - Documentation of clinical decreased vision
      - Lateral and full-face photographs

III. **Brow ptosis repair** may be considered medically necessary for reconstructive purposes when **ALL of the following** criteria are met:
   A. Photographs demonstrate the eyebrow is below the super orbital rim
   B. Visual field less than 20° above central fixation
   C. MRD1 of 2.0 mm or less
   D. Cannot be corrected by upper lid blepharoplasty alone
   E. Frontal or lateral photograph demonstrates visual field limitation consistent with the visual field examination, AND
   F. Does not have unstable myasthenia gravis or a thyroid condition
   G. **ALL of the following** information must be submitted:
      - Visual fields, including physician interpretation
      - MRD1 (marginal reflex distance) measurement
      - Documentation of clinically decreased vision
      - Lateral and full-face photographs

IV. **Blepharoplasty in anophthalmia** is considered medically necessary when the upper eyelid position interferes with the fit of eye prosthesis in the socket.

V. Blepharoplasty of the lower lids for excessive skin that does not correct a functional issue is considered **cosmetic** under the member benefit.

If requesting this service, please send the following documentation to support medical necessity:

- Signed clinical notes supporting a decrease in peripheral vision and/or upper field vision and excessive upper/lower lid skin
- Supporting pre-op lateral and full-face photographs
- Documented subjective patient complaints which justify functional surgery (vision, ptosis, etc.)
- Visual fields, including physician interpretation and recommendations (when applicable)
- MRD1 (marginal reflex distance) measurement (for blepharoptosis or brow ptosis repair)

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

This service is covered when it is medically indicated and determined not to be for cosmetic. The Medicare coverage language includes the identification of how to determine medical necessity. This is the language that has been adopted by Kaiser Permanente.

In order to determine coverage, the clinical history submitted by the requesting physician should include the reason for the surgery and the identification of the procedure to be done.

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Evidence and Source Documents

References:
Kaiser Permanente Coverage Contract Language
Medicare Coverage Manual /PROW Criteria

Medicare Part B News 180, March 2000, topic 1143 entry #5782, applicable to Washington State. And effective in March 2000 as of publish date.

Applicable Codes

Blepharoplasty – Medicare – Considered Not Medically Necessary:

CPT® Codes	Description
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad

Blepharoplasty – Medicare - Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid

Blepharoplasty – Non-Medicare - Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
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

Blepharoptosis - Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
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

Repair of Brow ptosis - Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description

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67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Date Created	Date Reviewed	Date Last Revised
04/30/1998	05/04/2010[MDCRPC], 03/01/2011[MDCRPC], 01/03/2012[MDCRPC], 11/06/2012[MDCRPC], 09/03/2013[MPC], 06/03/2014[MPC], 02/03/2015[MPC], 12/01/2015[MPC], 10/04/2016[MPC], 08/01/2017[MPC], 07/10/2018[MPC], 07/09/2019[MPC], 07/07/2020[MPC], 07/06/2021[MPC], 07/05/2022[MPC] , 07/11/2023[MPC], 07/11/2023[MPC], 08/02/2024[MPC]	02/04/2025

[MDCRPC] Medical Director Clinical Review and Policy Committee
[MPC] Medical Policy Committee

Revision History	Description
08/27/2015	Added new LCD L35536
09/08/2015	Revised LCD to L36281, L34886, L35008
10/04/2016	Added indication: OR limited to 10 to 15 degrees (untapped eye) laterally
06/15/2019	Added indication: Does not have unstable myasthenia gravis or a thyroid condition (No concerns about stability raised by Neurology for myasthenia gravis patients and normal thyroid lab if patient has pre-existing thyroid disease)
07/07/2020	Added Medicare LCA (A57191)
08/04/2020	Added Medicare LCA (A57642); MPC approved to adopt updates to clinical criteria for non-Medicare, separating indications for blepharoplasty and blepharoptosis repair.
02/04/2025	MPC approved to endorse credentialing preferences for Facial Surgery. 60-day notice is not required.

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