IMPORTANT REMINDER:
This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough review and consideration of generally accepted standards of medical practice, peer-reviewed medical literature, government agency/program approval status, and other indicia of medical necessity.

The purpose of this Clinical Policy is to provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits (“Benefit Plan Contract”) and applicable state and federal requirements including Local Coverage Determinations (LCDs), as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

SUBJECT:
Medical necessity determination of eyelid procedures for treatment of dermatochalasis and ptosis.

DESCRIPTION:
Ptosis is a downward displacement of the upper eyelid margin due to congenital defect, inflammation, nerve disorder, traumatic deformity, myogenic, mechanical or age related degenerative changes of the eyelid and supporting structures. Dermatochalasis is excessive eyelid skin, usually the result of the aging process with loss of elasticity. Dermatochalasis may also result from specific disorders, such as thyroid eye disease, floppy eyelid syndrome, blepharochalasis syndrome, trauma, or any condition that causes stretching of the upper eyelid skin.

Canthoplasty, also known as inferior retinacular suspension or lateral retinacular suspension, involves tightening the muscles or ligaments that
provide support to the outer corner of the eyelid. This procedure may be medically necessary where drooping of the outer corner of the eyelid interferes with vision.

**POLICY/Criteria:**
Selected procedures require pre-authorization for selected health plans as these procedures are also commonly used for cosmetic surgery. Envolve Vision Benefits, Inc. (Envolve Vision) will make the determination of medical necessity after review of the appropriate photographs, medical records and statements of medical necessity from the requesting provider.

Upper eyelid blepharoplasty is a surgical procedure performed to remove redundant upper eyelid skin and/or excessive fat in patients with dermatochalasis. Patients who are candidates for blepharoplasty are patients whose dermatochalasis causes interference with vision or visual field, related to daily activities such as, difficulty reading, driving, watching television, or using a computer due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue. Patients might describe the need to manually elevate their eyelid to see and also might experience a brow ache or headache from constant brow elevation, adopt a compensatory chin elevation, or bump their head on overhead objects.

Patients with ptosis or dermatochalasis may also complain of seeing their own lashes or feeling them irritating their cornea. Elevation of the lid via neosynephrine does not substantially improve these patients, as the skin remains redundant and overhanging. Patients who have normal lid margin position but severe dermatochalasis are candidates for blepharoplasty alone. Patients who undergo upper lid ptosis are not automatically candidates for simultaneous blepharoplasty simply because a small amount of skin is removed as part of the procedure.

Repair of brow ptosis (67900) may be considered medically necessary when documentation demonstrates brow ptosis to the extent it contributes to skin fold overlap and/or blepharoptosis meeting the criteria outlined below for upper eyelid blepharoplasty and/or ptosis surgery. Blepharoptosis (ptosis) repair (67901-67904; 67906; 67908-67909) is a surgical procedure performed to elevate the upper eyelid margin in patients with congenital or acquired ptosis.
and can be accomplished by procedures such as external levator resection or advancement, posterior approach Muller’s muscle and conjunctival resection, or frontalis suspension. Envolve Vision does not allow separate payment for a blepharoptosis procedure (CPT 67901-67908) and blepharoplasty procedure (CPT 15822, 15823) on the ipsilateral upper eyelid, in accordance with NCCI edits and CMS payment policy.

Canthoplasty (67950) is considered medically necessary as part of a blepharoplasty procedure to correct eyelids that sag so much that they pull down the upper eyelid so that vision is obstructed.

Documentation Requirements:

- Visual obstruction defined by **peripheral visual field testing** consistent with a minimum of 12 degrees or 30% loss of upper field of vision
- Clinical notes documenting **patient complaints** of visual impairment secondary to abnormal eyelid or brow position resulting in limitation of daily activities such as reading, driving, and difficulty seeing objects approaching from the periphery, or redundant upper eyelid skin resulting in looking through the eyelashes or seeing the upper eyelid skin.
- Good quality **frontal photograph** documenting **an MRD of 2 mm or less** with the gaze in primary position. The following photographs may be included as needed if helpful:
  - Oblique or lateral photographs further demonstrating overhanging excess skin as well as lash ptosis due to mechanical displacement by the overhanging skin fold.
  - Frontal photograph with the patient looking in down-gaze **documenting those cases in which the ptosis is worse in the down gaze position**.
  - Photograph with the **brows elevated or taped up to a normal position to document the effect of brow ptosis** when both eyelid ptosis repair and brow ptosis repair are planned.

Lower eyelid blepharoplasties (15820 & 15821) are always cosmetic and never approved as medically necessary.
An Envolve Vision Medical Director approves upper lid surgical repair on a case-by-case basis and the required documentation noted above is required at the time of the pre-authorization request:

**AUTHORIZATION PROTOCOLS:**
Selected procedures require pre-authorization for selected health plans. Services that do not require pre-authorization are subject to retrospective medical record review. Medical records must clearly document the medical necessity of the procedure(s).

Review will include the following:
- Evaluation of the upper eyelids in relation to the pupils as depicted in the photographs
- Evaluation of clinical notes
- Evaluation of visual field tests
- Request for consultation as needed

Professional services provided by duly licensed eye care providers must be within the scope of licensure as defined by applicable State guidelines and Local Coverage Determinations.

**DEFINITIONS:**

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

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

Blepharoptosis: drooping of the upper eyelid related to the position of the eyelid margin with respect to the eyeball and visual axis.

Pseudoptosis (“false ptosis”): For the purposes of this policy, the specific circumstance where the eyelid margin is 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 so as to become a “pseudo” lid margin.
Brow ptosis: drooping of the eyebrows to such an extent that excess tissue is pushed into the upper eyelid that may cause mechanical blepharoptosis and/or dermatochalasis

REFERENCES:
Wisconsin Physicians Service Insurance Corporation Local Coverage Determination L34528 Blepharoplasty, Kansas, Effective 10/1/2015
Noridian Healthcare Solutions, LLC Local Coverage Determination L33512 Blepharoplasty, Northern California, Effective 10/1/2015
Palmetto Government Benefits Administrators Local Coverage Determination L31696 Blepharoplasty, South Carolina, Effective 10/1/2015
First Coast Service Options, Inc. Local Coverage Determination L34028 Upper Eyelid and Brow Surgical Procedures, Florida, Effective 10/1/2015

CODING IMPLICATIONS:
The following codes for treatment and procedures are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Please refer to your State contract or applicable National and Local Coverage Determination for exact coverage implications.

Envolve Vision follows National Correct Coding Initiative (CCI) guidelines in processing claims for these services. If a claim is denied based upon CCI edits, an appeal must be submitted to Envolve Vision with a letter signed by the provider indicating the necessity of performing multiple services at the same encounter and the medical records clearly stating what additional information
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<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>ICD-10 Code Description</th>
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<tbody>
<tr>
<td>H02.401</td>
<td>Unspecified ptosis of right eyelid</td>
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<td>H02.403</td>
<td>Unspecified ptosis of bilateral eyelids</td>
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<td>H02.431</td>
<td>Paralytic ptosis of right eyelid</td>
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<td>H02.432</td>
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<td>H02.433</td>
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<td>H02.421</td>
<td>Myogenic ptosis of right eyelid</td>
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<td>H02.422</td>
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<td>H02.423</td>
<td>Myogenic ptosis of bilateral eyelids</td>
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<td>H02.31</td>
<td>Blepharochalasis right upper eyelid</td>
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<td>Blepharochalasis right lower eyelid</td>
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<td>Q10.2</td>
<td>Congenital entropion</td>
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<tr>
<td>Q10.3</td>
<td>Other congenital malformations of eyelid</td>
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**REVIEW/REVISION LOG**

<table>
<thead>
<tr>
<th>Revision</th>
<th>Date</th>
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<tbody>
<tr>
<td>Revised medical necessity and documentation guidelines for all procedures addressed in policy.</td>
<td>07/2016</td>
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</table>
## Update diagnoses to ICD-10, update references to current guidelines, update diagnoses for medical indications, rebrand to new corporate name
12/2015

## Addition of CPT and diagnosis codes, update to authorization procedures, change policy name
07/2015

12/2014

## Converted SOP to new format, changed Reference Number to comply with new SOP numbering policy.
08/2012

## Update to diagnoses that are considered for blepharoplasty/ptosis procedures
02/2011

## Annual review/revision
02/2006

## Update of visual field information for pre-certification; removal of references to the neosynephrine test; policy renumbered
02/2005

## Annual review/revision
02/2004

## Annual review/revision
02/2003