	Status
BlueCross BlueShield of Minnesota	Active

Medical and Behavioral Health Policy Manual
Section: Surgery
Policy Number: IV-17
Effective Date: 09/09/2009

BLEPHAROPLASTY AND BROW PTOSIS REPAIR

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. It may also be performed for cosmetic purposes in the absence of visual field obstruction. Brow ptosis (i.e., descent or droop of the eyebrows) can also produce or contribute to functional visual impairment**.**

Policy: Blepharoplasty and brow ptosis repair may be considered **MEDICALLY NECESSARY** when performed for reconstructive purposes when impairment of vision is documented.

The following visual field information must be provided as documentation of visual impairment:

1. The indication for surgery is supported if a difference of 12º or more or 30% superior visual field difference is demonstrated between visual field testing before and after manual elevation of the eyelids, OR
2. Visually significant brow ptosis may be documented by visual field testing with the brow elevated demonstrating a difference of 12º or more or 30% superior visual field difference, and
3. Visual fields need to meet accepted quality standards, whether they are performed by Goldmann technique or by use of a standardized automated technique

Visual fields are not necessary for patients with an anophthalmic socket who are experiencing ptosis or difficulty with their prosthesis.

For brow ptosis repair, photography should document the medical necessity for brow ptosis repair (drooping of brows and improvement of blepharoptosis or dermatochalasis/blepharochalasis by elevation of brows). In addition, frontal photographs are necessary.

Blepharoplasty of the lower lids is considered **COSMETIC**.

Coverage: **Prior authorization: Yes, ONLY for brow ptosis repair.**

Prior authorization for blepharoplasty: No.

However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Coding: *The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.*

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

15824 Rhytidectomy; forehead

15825 Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)

15826 Rhytidectomy; glabellar frown lines

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

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)

ICD-9 Procedure:

08.3 Repair of blepharoptosis and lid retraction

08.31 Repair of blepharoptosis by frontalis muscle technique with suture

08.32 Repair of blepharoptosis by frontalis muscle technique with fascial sling

08.33 Repair of blepharoptosis by resection or advancement of levator muscle or aponeurosis

08.34 Repair of blepharoptosis by other levator muscle techniques

08.35 Repair of blepharoptosis by tarsal technique

08.36 Repair of blepharoptosis by other techniques

08.37 Reduction of overcorrection of ptosis
08.86 Lower eyelid rhytidectomy
08.87 Upper eyelid rhytidectomy

Policy History:

Medical and Behavioral Health Policy Committee Review:
Reviewed September 10, 2008
Reviewed September 9, 2009

Medical Policy Committee Review:
Developed December 20, 1985
Reviewed April 13, 1993
Reviewed July 2, 1997 (No change necessary)
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Revised September 8, 2004
Reviewed September 14, 2005
Reviewed October 11, 2006
Revised November 15, 2006 (coverage section only)
Reviewed October 10, 2007

Medical Policy Subcommittee Review:
Reviewed October 1, 1998
Reviewed August 11, 1999
Reviewed December 13, 2000
Reviewed December 13, 2000
Reviewed November 14, 2001
Reviewed December 16, 2002
Reviewed November 12, 2003

Cross Reference: Excision of Redundant Skin, IV-24

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