

Blepharoplasty

Blepharoplasty is a surgical procedure performed on the upper or lower eyelids for correcting defects, deformities and disfigurements of the eyelids. The procedure typically involves the excision and the removal of, or the repositioning of (or both) excess tissue, such as skin and adipocyte fat, and the reinforcement of the corresponding muscle and tendons. Reconstructive or functional blepharoplasty is most commonly performed to correct diminished visual fields caused by the weight of excess tissue of the upper eyelid, called ptosis. Reconstructive blepharoplasty is also performed to treat eyelid lesions or alterations resulting from inflammatory processes such as Graves' disease, blepharochalasis and floppy eyelid syndrome. Trauma to the eyelid and/or orbit may also be indications for blepharoplasty.

The following Blepharoplasty CPT codes require preauthorization:

- ❖ 15820 Blepharoplasty, lower eyelid
- ❖ 15821 Blepharoplasty, lower eyelid - with excessive skin weighting down lid
- ❖ 15822 Blepharoplasty, upper eyelid
- ❖ 15823 Blepharoplasty, upper eyelid - with excessive skin weighting down lid

I. Criteria for Initial Approval

Blepharoplasty will be considered for coverage when **all** of the criteria below are met, confirmed with supporting medical documentation. If multiple procedures are requested, the criteria for **each** procedure must be met:

Lower eyelid blepharoplasty (CPT 15820 and 15821) - Typically considered a cosmetic procedure, but may be considered reconstructive and medically necessary when the following criteria are present:

- Adults 18 years of age and older.
- Performed by an ophthalmologist (oculoplastic surgeon), plastic surgeon or ear, nose and throat (ENT) specialist.
- Presence of lower eyelid edema due to a metabolic or inflammatory disorder when the edema is causing a persistent visual impairment (e.g., secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome) and is unresponsive to conservative medical management.
- Presence of lower lid dysfunction causing inability to close the eyelid (lagophthalmos).
 - Documented facial nerve damage.
 - Defect caused by trauma or tumor-ablative surgery.

- Functional impairment is present and includes both:
 - Documented uncontrolled tearing or irritation or exposure keratitis.
 - Conservative treatments attempted and failed.

Upper eyelid blepharoplasty (CPT 15822 and 15823) - May be considered reconstructive and medically necessary when the following criteria are present:

- Adults 18 years of age and older.
- Performed by an ophthalmologist (oculoplastic surgeon), plastic surgeon or ear, nose and throat (ENT) specialist.
- Considered for patients with significant deformity related to trauma, tumor-ablative surgery, Grave's disease, floppy eyelid syndrome, blepharitis, or developmental anomalies.
- Diagnosis of blepharochalasis, dermatochalasis or pseudoptosis.
- Documentation of functional visual complaints related to eyelid abnormality including:
 - The patient's subjective complaint of interference with vision or visual field-related activities.
 - Painful symptoms of blepharospasm.
 - Chronic eyelid dermatitis due to redundant skin refractory to medical therapy.
 - Visual impairment caused by abnormal or redundant upper eyelid structures.

II. Required Clinical Information

Blepharoplasty

Criteria for coverage (in **Section I.**) must be met. The following clinical information must be provided:

- Recent history and physical exam.
- Imaging and interpretation of visual field testing. Please include:
 - Photodocumentation, including a frontal, lateral and/or oblique photograph (when indicated):
 - Frontal photographs, canthus to canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash or position of the true lid margin or the pseudo-lid margin.
 - Close up lateral photographs with eyes open, upgaze and eyes closed.

- Frontal and oblique photos are needed to demonstrate redundant skin.
 - Results from either a Goldmann Perimeter or another programmable automated perimeter visual field testing method.
- Diagnosis and description of functional impairment that supports the need for blepharoplasty, including:
 - Office records that indicate signs and symptoms of the vision disturbance.
 - Specific symptoms, duration and severity must be noted.

III. Coverage Limitations and Exclusions.

Procedures, in the absence of a functional visual impairment, or being performed for the sole purpose of improving appearance are excluded from coverage, as these are considered cosmetic in nature and not medically necessary.

- *Ectropion (eversion or turning outward of the eyelid) and entropion (inversion or turning inward of the eyelid) procedures do not require prior authorization.*

IV. Length of Authorization for Initial Therapy

A Blepharoplasty procedure will be authorized for 6 months when criteria for initial approval are met.

V. Billing Code/Information

CPT/HCPCS Codes:

- ❖ 15820 Blepharoplasty, lower eyelid
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Prior authorization of benefits is not the practice of medicine nor the substitute for the independent medical judgment of a treating medical provider. The materials provided are a component used to assist in making coverage decisions and administering benefits. Prior authorization does not constitute a contract or guarantee regarding member eligibility or payment. Prior authorization criteria are established based on a collaborative effort using input from the current medical literature and based on evidence available at the time.

Approved by MDH Clinical Criteria Committee: 8/31/2021
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