IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blepharochalasis</td>
<td>Excessive skin on the eyelids due to chronic blepharedema, which physically stretches the skin.</td>
</tr>
<tr>
<td>Blepharoptosis</td>
<td>Drooping of the upper eyelid, which relates to the position of the eyelid margin with respect to the eyeball and visual axis.</td>
</tr>
<tr>
<td>Brow Ptosis</td>
<td>Drooping of the eyebrows to such an extent that excess tissue is pushed into the upper eyelid. It is recognized that in some instances the brow ptosis may contribute to significant superior visual field loss. It may coexist with clinically significant dermatochalasis and/or lid ptosis.</td>
</tr>
<tr>
<td>Blepharoplasty</td>
<td>Surgical removal of redundant skin, muscle and fatty tissue from the eyelids for the purpose of deformity reconstruction, functional improvement of abnormalities or appearance enhancement.</td>
</tr>
<tr>
<td>Cosmetic blepharoplasty</td>
<td>When blepharoplasty is performed to improve a patient’s appearance in the absence of any signs or symptoms of</td>
</tr>
</tbody>
</table>
functionality abnormalities, the procedure is considered cosmetic.

Reconstructive blepharoplasty

When blepharoplasty is performed to correct visual impairment caused by drooping of the eyelids (ptosis); repair defects caused by trauma or tumor-ablative surgery (ectropion/entropion corneal exposure); treat periorbital sequelae of thyroid disease and nerve palsy; or relieve the painful symptoms of blepharospasm, the procedure should be considered reconstructive. This may involve rearrangement or excision of the structures with the eyelids and/or tissues of the cheek, forehead and nasal areas. Occasionally a graft of skin or other distant tissues is transplanted to replace deficient eyelid components.

Dermatochalasis

Excessive skin on the eyelids as a result of loss of skin elasticity with aging.

Pseudoptosis or “false ptosis”

Excessive skin overhanging the eyelid margin and creating the appearance of true blepharoptosis, although the eyelid margin is usually in an appropriate position with respect to the eyeball and visual axis.

Related Guidelines

Cosmetic Surgery

Guideline

The goal of functional or reconstructive surgery is to restore normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia or developmental errors. Members are eligible for coverage of blepharoplasty procedures and repair of blepharoptosis when performed as functional or reconstructive surgery to correct any of the following (list not meant to be all-inclusive):

- Congenital ptosis with risk for amblyopia.
- Ectropion and Entropion (visual fields not necessary).
- Symptomatic dermatitis of pretarsal skin caused by redundant upper-lid skin.
- Prosthesis difficulties in an anophthalmia socket.
- Symptomatic redundant skin weighing down upper lashes.
- Visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis.
- To relieve painful symptoms of blepharospasm

Documented patient complaints justifying functional surgery that are commonly found in patients with ptosis, pseudoptosis or dermatochalasis include:

- Interference with vision or visual field.
- Difficulty reading or driving due to upper eyelid drooping.
- Looking through the eyelashes or seeing the upper eyelid skin.
- Chronic blepharitis refractory to ≥ 3 months of supervised therapy

Documentation

Documentation must include history and physical with appropriate patient complaints, visual fields and photographs, as described below.
Photographic evidence: Must be in the form of prints, not slides, imprinted with the patient’s name and date of visit. Photographs must be frontal (canthus-to-canthus), with the head perpendicular to the plane of the camera, to demonstrate a skin rash or the position of the true lid margin or the pseudo-lid margin. The photos must be of sufficient clarity to show a light reflex on the cornea. If redundant skin coexists with true lid ptosis, additional photos must be taken with the upper lid skin retracted to show the actual position of the true lid margin. Oblique photos are only needed to demonstrate redundant skin weighing down upper eyelashes when this is the only indication for surgery.

Photographs must demonstrate ≥ 1 of the following:
- The upper eyelid margin rests 2 mm or less above the corneal light reflex.
- The upper eyelid skin rests on the eyelashes.
- The upper eyelid indicates the presence of dermatitis.
- The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmia socket.

Visual fields: Must be recorded using either the Goldmann Perimeter (III 4-E test object; perimeter not accepted if hand-drawn) or a programmable perimeter (i.e., Humphrey or other computerized visual-field test equivalent to a screening field with a single-intensity strategy using a 10db stimulus) to test a superior (vertical) extent of 50–60 degrees above fixation, with targets presented at a minimum 4-degree vertical separation, starting at fixation, while using no wider than a 10-degree horizontal separation. Preferred programs on the Humphrey perimeter include the 36-point screening test and the 120-point, full-field screening test. Each eye should be tested with the upper eyelid at rest and repeated with the elevated eyelid to demonstrate an expected surgical improvement that meets or exceeds the criteria. The superior visual with the upper eyelid at rest should be restricted to within 30 degrees of fixation and there should be a minimum of 12 degrees of improvement in the superior visual field (vertical extent) with the upper eyelids taped.

Limitations/Exclusions
The Plan does not consider blepharoplasty procedures performed solely for cosmetic reasons to be medically necessary.

Coding Criteria:
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

| Applicable CPT and Diagnosis Codes |

References


Medical Policy:
Blepharoplasty (Commercial)

Specialty-matched clinical peer review.

Revision history

<table>
<thead>
<tr>
<th>DATE</th>
<th>REVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/2020</td>
<td>Changed &quot;The upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex&quot; to &quot;The upper eyelid margin rests 2 mm or less above the corneal light reflex&quot;.</td>
</tr>
<tr>
<td>12/12/2019</td>
<td>Reformatted and reorganized policy, transferred content to new template</td>
</tr>
<tr>
<td>11/11/2019</td>
<td>Added that blepharoplasty is considered medically necessary to relieve painful symptoms of blepharospasm.</td>
</tr>
</tbody>
</table>