Subject: Cosmetic and Reconstructive Eye Procedures

Background:

Blepharoplasty refers to the removal of eyelid skin and relates to the position of the eyelid margin with respect to the eyeball and visual axis. Blepharoptosis (ptosis of the eyelid) refers to the drooping of the upper eyelid due to congenital or acquired abnormalities of the muscles that elevate the eyelid. Brow ptosis, which is drooping of the eyebrows to such an extent that excess tissue is pushed into the upper eyelid, may contribute to functional visual field impairment.

Authorization:

Prior authorization is required for all the following reconstructive eye procedures requested for members enrolled in commercial (HMO, POS, and PPO) products.

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation and/or color photographs may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation — via HPHConnect Clinical Upload or secure fax (800-232-0816)
- Photographs — HPHConnect Clinical Upload function, email (utilization_requests@harvardpilgrim.org), or mail (Utilization Management, 1600 Crown Colony Dr., Quincy, MA 02169). Please note that photographs should not be faxed as faxed photos cannot be utilized in making a medical necessity determination.

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Resources and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here.) Members may access these materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

Policy and Coverage Criteria:

For this policy, Harvard Pilgrim Health Care (HPHC) draws upon the following 2018.1 InterQual® criteria, which HPHC has customized:

- Brow Ptosis Repair (Version 2019.1)
- Blepharoplasty or Blepharoptosis Repair for Blepharoplasty (Version 2019.1)
- Blepharoplasty or Blepharoptosis Repair for Blepharoptosis Repair (Version 2019.1)
- Entropion Repair (Version 2019.1)
- Ectropion Repair (Version 2019.1)

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.
In addition, HPHC requires the following criteria:

**Brow Ptosis Repair**
- Member has a correctible upper visual field loss (to within 30 degrees of the central fixation point) that cannot be corrected by upper lid blepharoplasty; AND
- Visual field loss improves by at least 20 degrees when the brow is lifted to the correct anatomical position; AND
- Frontal photographic documentation documenting the size, location and characteristics must be mailed or emailed to HPHC.

**Upper Blepharoplasty**
Harvard Pilgrim Health Care (HPHC) considers upper eyelid blepharoplasty as reasonable and medically necessary when documentation confirms ANY of the following:
- Member has complaints of interference with daily visual tasks or visual field-related activities confirmed by ALL of the following:
  - Margin reflex distance (MRD) of 2.5 mm or less, AND
  - Functional visual impairment or visual field obstruction related to excess upper eyelid tissue (e.g., difficulty reading, walking, or driving) when documentation confirms ALL the following:
    - Eyelid at rest limits the upper visual field to within 30 degrees (measured from the central fixation point); AND
    - Redundant eyelid tissue and/or the upper eyelid taped with eyelid margin in an anatomically correct position demonstrates at least 20 degrees improvement in the visual field defect; AND
    - Visual fields need to meet accepted quality standards, whether they are performed by the Goldmann perimeter technique or by use of a standardized automated perimetry technique; OR
  - ANY of the following:
    - Prosthesis difficulties in an anophthalmic socket, OR
    - Defects (e.g., corneal exposure, entropion, entropion, pseudotrichiasis) that predispose the member to corneal or conjunctival irritation, OR
    - Peri-orbital sequelae of thyroid disease and nerve palsy

**Lower Blepharoplasty**
Harvard Pilgrim Health Care (HPHC) considers lower eyelid blepharoplasty as reasonable and medically necessary when documentation confirms the following:
- Margin reflex distance (MRD) of 2.5 mm or less, OR
- Prosthesis difficulties associated with an anophthalmic socket, OR
- Conditions causing corneal or conjunctival irritation (e.g. entropion, ectropion, pseudotrichiasis, or chronic dermatitis caused by redundant eyelid tissue), OR
- Periorbital sequelae of thyroid disease, facial paralysis, or nerve palsy causing a functional impairment (e.g. incomplete closure of the eye), and unresolved after adequate medical treatment, OR
- Functional defects caused by trauma or tumor-ablative surgery

**Upper Eyelid Blepharoptosis**
Harvard Pilgrim Health Care (HPHC) considers upper eyelid blepharoptosis repair as reasonable and medically necessary when documentation confirms the following:
• Prosthesis difficulties in an anophthalmic socket, OR
• Margin reflex distance (MRD) of 2.5 mm or less, OR
• Defects (e.g., corneal exposure, ectropion, entropion, pseudotrichiasis) that predispose the member to corneal or conjunctival irritation, OR
• Painful symptoms of blepharospasm (e.g., excessive blinking, uncontrollable contractions or twitching of eye muscles, sensitivity to bright light), OR
• Peri-orbital sequelae of thyroid disease and nerve palsy, OR
• Visual field obstruction when visual field testing confirms ALL the following:
  o Eyelid at rest limits the upper visual field to within 30 degrees (measured from the central fixation point); AND
  o Redundant eyelid tissue and/or the upper eyelid taped with eyelid margin in an anatomically correct position demonstrates at least 20 degrees improvement in the visual field defect; AND
  o Visual fields need to meet accepted quality standards, whether they are performed by the Goldmann perimeter technique or by use of a standardized automated perimetry technique; AND
• Visual fields are not necessary for individuals with an anophthalmic socket who are experiencing ptosis of difficulty with their prosthesis.

Exclusions:
Harvard Pilgrim Health Care (HPHC) considers reconstructive eye procedures as not medically necessary for all other indications. In addition, HPHC does not cover:
• Medial or lateral canthopexy
• Drugs, biologicals, facility/hospital, laboratory and radiology services, professional services, or other incidental services directly related to a cosmetic surgery or procedure
• Procedures for cosmetic reasons only

Guidelines:
In accordance with MA Chapter 233 (An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment), HPHC covers treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome for any member enrolled in any HPHC plan delivered, issued or renewed within the commonwealth. Medical record documentation from a treating provider must confirm that the treatment is medically necessary for correcting, repairing or ameliorating the effects of HIV associated lipodystrophy syndrome.

Coding:
Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive herniated fat pad</td>
</tr>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid.</td>
</tr>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead, or coronal approach</td>
</tr>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)</td>
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</tbody>
</table>

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Cosmetic and Reconstructive Eye Procedures

<table>
<thead>
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<th>CPT® Code</th>
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<tbody>
<tr>
<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67908</td>
<td>Repair of blepharoptosis; conjunctivo-tarso-Müller’s muscle levator resection (e.g., Fasanella-Servat type)</td>
</tr>
<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
</tr>
<tr>
<td>67911</td>
<td>Correction of lid retraction</td>
</tr>
<tr>
<td>67912</td>
<td>Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)</td>
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<tr>
<td>67914</td>
<td>Repair of ectropion; suture</td>
</tr>
<tr>
<td>67915</td>
<td>Repair of ectropion; thermocauterization</td>
</tr>
<tr>
<td>67916</td>
<td>Repair of ectropion; excision tarsal wedge</td>
</tr>
<tr>
<td>67917</td>
<td>Repair of ectropion; extensive (e.g., tarsal strip operations)</td>
</tr>
<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
</tr>
<tr>
<td>67922</td>
<td>Repair of entropion; thermocauterization</td>
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<tr>
<td>67923</td>
<td>Repair of entropion; excision tarsal wedge</td>
</tr>
<tr>
<td>67924</td>
<td>Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs)</td>
</tr>
<tr>
<td>67950</td>
<td>Canthoplasty (reconstruction of canthus)</td>
</tr>
<tr>
<td>67961</td>
<td>Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin</td>
</tr>
</tbody>
</table>

Billing Guidelines:
Member’s medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

References:
4. CMS LCD L34528 Blepharoplasty, Blepharoptosis and Brow Lift


### Summary of Changes:

<table>
<thead>
<tr>
<th>Date</th>
<th>Changes</th>
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<tbody>
<tr>
<td>2/20</td>
<td>Criteria and coding updated</td>
</tr>
<tr>
<td>4/19</td>
<td>InterQual® criteria adopted; criteria revised</td>
</tr>
<tr>
<td>10/17</td>
<td>Policy coverage criteria refined; background and references updated</td>
</tr>
<tr>
<td>10/16</td>
<td>Update to language to support mandate for HIV lipodystrophy</td>
</tr>
<tr>
<td>4/16</td>
<td>Minor formatting edits; updated exclusions</td>
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<tr>
<td>4/15</td>
<td>Add coding profile and reference.</td>
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</table>

**Approved by Medical Policy Committee:** 2/25/20

**Approved by Clinical Policy Operational Committee:** 5/11, 5/12, 2/13, 3/14, 4/15, 4/16, 10/16; 10/17; 4/19; 5/20

**Policy Effective:** 08/01/20

**Initiated:** 7/1/10

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