

Local Coverage Determination (LCD): Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (L34028)

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First Coast Service Options, Inc.	A and B MAC	09102 - MAC B	J - N	Florida
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LCD Information

Document Information

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LCD Title

Blepharoplasty, Blepharoptosis Repair and Surgical
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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for blepharoplasty and surgical procedures of the brow. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for blepharoplasty and surgical procedures of the brow and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

IOM Citations:

- CMS IOM Publication, 100-02, *Medicare Benefit Policy Manual*,
 - Chapter 16, Section 120 General Exclusions from Coverage

- CMS IOM Publication, 100-08, *Medicare Program Integrity Manual*,
 - Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.

Code of Federal Regulations (CFR) References:

- CFR, Title 42, Volume 2, Chapter IV, Part 411.15(h) Particular services excluded from coverage.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

Blepharoplasty may be performed for functional, reconstructive or cosmetic purposes. Functional or reconstructive eyelid surgery is performed to improve abnormal function, reconstruct deformities, repair defects due to trauma or to restore normalcy to the eyelids.

Covered Indications

Functional blepharoplasty procedures and surgical procedures of the brow will be considered medically reasonable and necessary in the following situations:

1. When the goal of the surgery is to restore function and normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia, or developmental errors¹ or;
2. When there is interference with visual field, near or far visual impairment, or difficulty reading due to any of the following:
 - Dermatochalasis¹
 - Blepharochalasis¹
 - Blepharoptosis^{1,2}
 - Brow ptosis causing malposition of the upper eyelid¹ and demonstrating a MRD1 (Margin reflex distance) of 2 mm or less³
 - Looking through the eyelashes or seeing the upper eyelid skin as commonly seen with ptosis
 - Pseudoptosis¹
 - When there is visual impairment secondary to redundant skin weighing down on upper lashes¹ resulting in eye strain, headache and loss of vision.^{2,4,5}
 - When there is chronic, symptomatic dermatitis³ of pretarsal skin¹ caused by redundant upper lid skin which has not been successfully treated by conservative measures such as education regarding hygiene,

antibiotics, etc.; or

3. Visual field testing demonstrating a 12 to 15 degree superior field loss or 24% to 30% superior visual field impairment³; or
4. When there is the presence of prosthesis difficulties in an anophthalmic socket^{3,6}; or
5. When there is laxity of the lower eyelid tissues causing lower eyelid ectropion resulting in eye irritation and inflammation and excessive tearing²; or
6. When there is inward rotation of the eyelid margin causing entropion where the eyelashes are contacting the cornea resulting in discomfort, redness, tearing, and foreign body sensation²; or
7. Lower eyelid edema, tumor or mass causing signs and symptoms of eyelid ectropion.^{1,2}

Limitations

- Blepharoplasty and surgical procedures of the brow performed for the sole purpose of improving appearances are considered not medically reasonable and necessary.

Notice: Services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

Summary of Evidence

The American Academy of Ophthalmology¹ presented a review of the indications for upper and lower blepharoplasty, an operation where redundant tissue (skin, muscle, or fat) is removed from the eyelid(s). Blepharoplasty is performed for functional purposes or cosmetic purposes. The intention of functional surgery is to restore normalcy to structures that have been compromised by trauma, infection, inflammation, degeneration, neoplasia, or developmental abnormalities. The author states that blepharoplasty includes procedures to repair ptosis, eyelid retraction, entropion, ectropion, trichiasis, or defects after excision of tumors.

Visual field loss can result from malposition of the upper eyelids. Superior visual field impairment ranges from 20% loss of visual field for mild ptosis to 64% in advanced/severe cases where the eyelid is located in the middle of the pupil.

A common functional indication for upper eyelid blepharoplasty is dermatochalasis, a superior visual field defect secondary to redundant upper eyelid tissue that overhangs the eyelid margin. Pseudoptosis may be defined as the upper eyelid in an abnormally low position due to mechanical weight of the excess eyelid. Dermatochalasis may lead to pseudoptosis. This excessive skin may result in asthenopic symptoms, persistent blepharconjunctivitis (functional dermatochalasia) and dry eye symptoms. Levator aponeurosis dehiscence or disinsertion or neurologic factors found in true blepharoptosis may also be seen with dermatochalasis. Dermatochalasis and brow ptosis are often seen together therefore brow lift may be indicated in conjunction with blepharoplasty. In addition to the functional problems described above, inflammatory disorders of the orbit or eyelids may be treated by blepharoplasty. One such example of an inflammatory disorder that may warrant upper eyelid blepharoplasty is Graves' ophthalmopathy a condition characterized by edema and fullness of the eyelids with anterior prolapse of orbital fat and lacrimal gland tissue. Blepharochalasis, a disease where recurrent episodes of idiopathic eyelid edema results in stretching and redundancy of the eyelid tissues and floppy eyelid syndrome, that might be related to blepharochalasis, causes chronic papillary conjunctivitis and may be treated effectively with blepharoplasty. Blepharoplasty may be useful when skin grafts are required secondary to trauma of the eyelid or orbit to replace avulsed or burned eyelid tissue or

to cover loss or atrophy of orbital fat. Subsequent trimming of the healed grafts may be required.

Functional lower eyelid blepharoplasty is indicated when middle aged or elderly patients experience large lower eyelid edema secondary to systemic corticosteroid therapy, myxedema, Graves' disease, nephrotic syndrome, or other metabolic or inflammatory disorders. Lower lid blepharoplasty may also be required in cases of epiblepharon or entropion (extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea).

A systematic review of functional indications for upper eyelid ptosis and blepharoplasty surgery.

Cahill and colleagues³ conducted a literature search of the PubMed and Cochrane Library databases on July 24, 2008. The search strategy used to search the databases included keywords such as blepharoptosis, eyelid drooping, eyelid diseases, blepharoplasty and palpebral ptosis. Inclusion criteria were as follows: the publication was an original report, relevant to surgical treatment of ptosis or upper eyelid dermatochalasis, provided a report of a primary outcome of functional improvement, and follow-up period of at least 6 weeks (if a surgical series). Initial search retrieved 87 studies and was subsequently pared down to 13 final studies. The objective of this review was to evaluate the functional indications and outcomes of blepharoplasty and blepharoptosis repair by answering the following questions: (1) What are the functional indications for surgery? (2) What are the results of surgery? (3) Does surgery for ptosis or dermatochalasis improve visual function or quality of life?

In these 13 studies the authors determined that functional surgery was commonly performed for indications such as impaired visual acuity, decreased peripheral vision, a compensatory chin-up backward head tilt, difficulty reading, dermatitis, eye strain and fatigue, and difficulty wearing prosthesis in an anophthalmic socket. The authors also concluded that the surgeries performed in the studies to repair blepharoptosis and upper eyelid dermatochalasis resulted in significant improvement in vision for the patients. Ptosis and upper eyelid blepharoplasty surgery were found to be functionally beneficial for each of these quantitative findings: MRD1 of <2 mm measured in primary gaze, superior visual field loss of 12 degrees or 24% and down-gaze ptosis impairing reading documented by MRD of <2 mm measured in down gaze. Other quantitative findings that surgery provided a benefit also included chin-up backward head tilt due to lids, symptoms of discomfort or eye strain due to droopy lids, central visual interference due to upper eyelid position, and patient self-reported functional impairment.

The third question, concerning improved visual function or quality of life was answered primarily through studies by Battu et al. and Federici et al.

Battu et al, conducted a prospective study of the effect of unilateral and bilateral ptosis surgery on subjective visual function and quality of life outcome measures. The study used questionnaires pertaining to vision-related activities, symptoms, and well-being. Fifty consecutive adults ranging in age from 22 to 93 years (mean, 65 years) completed the questionnaires before ptosis surgery and then 6 to 8 weeks after surgery. All of the patients had ptosis severe enough to cause visual field limitation, with MRD1 of 2 mm or less. All patients achieved improved eyelid position after surgery and statistically significant improvement in the performance categories such as fine manual work, hanging or reaching for objects above eye level, reading, watching television, reading road signs, seeing stop lights above while driving, working on a computer or typewriter. There were no symptoms or activities that showed a mean worsening after ptosis surgery.

A subsequent study by Federici et al. used the same questionnaires before and after surgery as Battu et al. This study was a larger cohort of 100 patients, ranging in age from 22 to 93 years (mean, 65.8 years). Significant improvement in ache around eyes, self-image, tearing, redness, burning, dryness, economic status, and general well-being were reported. In addition to the improved symptom categories in the previous study, Federici et al. evaluated additional activity categories with results showing statistically significant improvement when performing one's occupation, playing a sport, and walking without assistance. Patient's preoperative functional impairment was

more strongly associated with their degree of functional improvement after surgery than their preoperative eyelid measurements or visual field tests.

A review of eyelid malposition repair and current techniques.

Guthrie and colleagues² conducted a review of literature and technique in eyelid malposition repair. The authors stated that defects of the eyelid pose a challenge to surgeons due to the delicate nature of both its form and function.

According to the authors, prior to performing blepharoplasty, it is important that patients be both medically and psychologically prepared to undergo the procedure and the recovery. A thorough medical and surgical history must be taken and a detailed examination of both the orbits and the face as a whole must be performed.

The authors described conditions of the eyelid that may warrant a surgical procedure as the following:

Entropion which is defined as inward rotation of the eyelid margin is one of the most commonly seen eyelid malposition defects. The inward rotation of the eyelid leads to contact of eyelid epithelium and eyelashes to the cornea causing corneal irritation and discomfort including redness, tearing, and foreign body sensation. Involutional entropion the most common form of this condition is seen in the aging, and is a laxity in the medial and lateral canthal tendons, combined with tarsal thinning which results in diminished horizontal support of the lower lid. Involutional entropion can be congenital, but is a rare condition. Another form of entropion, cicatricial entropion, has many causes such as trauma, burns, chronic medication use, and infection.

Another form of eyelid malposition is ectropion which is defined as a turning out of the eyelid margin. The eversion of the eyelid leads to corneal and conjunctival exposure causing eye irritation, inflammation, and epiphora (excessive tearing). Ectropion can be broken down into categories of involutional, cicatricial, paralytic, and mechanical. Involutional ectropion, the most frequently encountered type, is caused by age-related lower eyelid laxity. Laxity is a result of a combination of gravity and atrophy of the orbicularis muscle and medial and lateral canthal tendons. Paralytic ectropion is paralysis of the orbicularis muscle as result of trauma, Bell's palsy, surgery, and/or stroke. Cicatricial ectropion results from anterior lamella shortening due to scarring. Lastly mechanical ectropion occurs secondary to an eyelid mass or tumor.

Eyelid retraction, most commonly affecting the lower eyelid, may be seen in patients with scarring from trauma or surgery, thyroid ophthalmopathy, unilateral ptosis with resultant contralateral over activity of the levator palpebrae muscle, Graves' disease, Parinaud's syndrome, or chronic corticosteroid use.

Blepharoptosis, drooping of the upper eyelid, may be categorized as congenital or acquired. Congenital blepharoptosis is generally caused by embryonic failure of the levator muscle to develop. Acquired blepharoptosis is the most common form of blepharoptosis and can be either involutional or senile ptosis. This condition is caused by the disinsertion or dehiscence of the levator aponeurosis from the tarsus. On exam, there is general poor levator function, with worsening of the ptosis on downward gaze, and a high lid crease. These patients tend to do quite well with surgical intervention.

Analysis of Evidence (Rationale for Determination)

The available literature supports that upper eyelid blepharoplasty is an effective and safe procedure for correcting blepharochalasis and dermatochalasis with few side effects. Dermatochalasis and blepharochalasis may lead to blepharoptosis resulting in visual impairment, infection, inflammation, blepharoconjunctivitis and dry eye symptoms¹ ultimately adversely impacting the quality of life for patients.

The available literature supports that lower lid blepharoplasty is a safe and effective procedure to correct functional entropion and ectropion with few side effects. Entropion and ectropion are both conditions of the lower eyelid that may result in corneal irritation, discomfort including redness, tearing, foreign body sensation, inflammation, and excessive tearing.²

The literature supports MRD1 (marginal reflex distance) or the distance between the center of the pupillary light reflex to the upper eyelid margin to be the measurement that is most predictive of visual field loss.³ A MRD1 of 4 to 5 mm is generally considered normal² which equates to an superior field that measures approximately 50 degrees.³ The superior field impairment ranges from 24% to 30% in a MRD1 of 2 mm, which corresponds to 12 to 15 degrees of superior visual field loss. The available literature supports MRD1 of 2 mm or less as an indication of functional visual field impairment.

The literature is limited and does not provide strong data related to the prosthesis difficulties in an anophthalmic socket, however the literature does support excessive dermatochalasis that affects prosthetic function in the anophthalmic socket as functional indication for blepharoplasty.⁴

The available literature supports that pseudoptosis where the eyelid is abnormally low due to mechanical weight of upper eyelid as a result of dermatochalasis¹ as an indication for blepharoplasty. Pseudoptosis is often seen with other conditions such as brow ptosis and may cause impairment of the field of vision impacting the quality of life for the patient.

Large amount of lower eyelid edema especially in middle age or elderly, masses and tumors causing stretching and redundancy of lower eyelid tissue^{1,2} are supported in the literature as secondary causes of ectropion. The literature supports blepharoplasty surgery for correcting lower eyelid ectropion as result of edema, mass or tumor.

General Information

Associated Information

Refer to the Local Coverage Article: Billing and Coding: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow (A57025) for documentation requirements, utilization parameters and all coding information.

Sources of Information

N/A

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Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
03/21/2021	R3	<p>This revised LCD published 02/04/2021 will become effective 03/21/2021. The proposed LCD and related Billing and Coding Article will provide limited coverage for upper and lower blepharoplasty as well as repair of brow ptosis when performed for functional indications.</p> <p>2020PITLAB019</p>	<ul style="list-style-type: none"> • Creation of Uniform LCDs Within a MAC Jurisdiction
01/08/2019	R2	<p>Revision Number: 2 Publication: September 2019 Connection LCR A/B2019-052</p> <p>Explanation of Revision: Based on CR 10901, the LCD was revised to remove all billing and coding and all language not related to reasonable and necessary provisions (“Bill Type Codes”, “Revenue Codes”, “CPT/HCPCS Codes”, “ICD-10 Codes that Support Medical Necessity”, “Documentation Requirements” and “Utilization Guidelines” sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. The effective date of this revision is for claims processed on or after January 8, 2019, for dates of service on or after October 3, 2018.</p> <p>01/08/2019: At this time 21st Century Cures Act will apply</p>	<ul style="list-style-type: none"> • Other (Revisions based on CR 10901)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.	
10/01/2017	R1	<p>Revision Number: 1</p> <p>Publication: November 2017 Connection</p> <p>LCR A/B2017-049</p> <p>Explanation of revision: Based on Change Requests (CR) 9658, 9668, 10236, and 10259, the "CMS National Coverage Policy" section of the LCD was updated. The effective date of this revision is for dates of service on or after October 1, 2017.</p>	<ul style="list-style-type: none"> Provider Education/Guidance

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)

A57025 - Billing and Coding: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow

A58587 - Response to Comments: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow

LCD(s)

DL34028 - Blepharoplasty and Surgical Procedures of the Brow

Related National Coverage Documents

N/A

Public Version(s)

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Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

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