Local Coverage Determination (LCD)

LCD - Blepharoplasty (L33944)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
CGS Administrators, LLC	MAC - Part A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	MAC - Part A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	MAC - Part B	15202 - MAC B	J - 15	Ohio

LCD Information

Document Information

LCD ID
L33944

LCD Title
Blepharoplasty

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 11/02/2023

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Notice Period End Date
N/A

Issue

Issue Description

This LCD outlines limited coverage for this service with specific details under Coverage Indications, Limitations and/or Medical Necessity.

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1862(1)(10) prohibits payment for cosmetic surgery. Procedures performed only to approve appearances without a functional benefit are not covered by Medicare.

CMS Publications:

CMS Publication 100-02; *Medicare Benefit Policy Manual*, Chapter 16:

20.2.1 Categorical Denials

120 Cosmetic Surgery

CMS Publication 100-04; *Medicare Claims Processing Manual*, Chapter 30:

20.2.1 Denials for Which the Limitation on Liability Provision Does Not Apply - Categorical Denials

50 Form CMS-R-131 Advance Beneficiary Notice (ABN)

90 Form CMS-20007-Notice of Exclusions from Medicare Benefits (NEMBs)

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

Medicare does not cover cosmetic surgery or expenses incurred in connection with such surgery. Cosmetic surgery is defined by Medicare as: "any surgical procedure directed at improving appearance, except when required for the prompt [i.e., as soon as medically feasible] repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose" (CMS Publication 100-2; *Medicare Benefit Policy Manual*, Chapter 16, Section 120). This local coverage determination provides additional guidance on CGS covered indications and limitations of coverage for blepharoplasty surgery

The American Society of Plastic and Reconstructive Surgeons has published the following definitions:

1. **Blepharoplasty** may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. It may be either reconstructive or cosmetic (aesthetic).
2. **Cosmetic Blepharoplasty:** When blepharoplasty is performed to improve a patient's appearance in the absence of any signs or symptoms of functional abnormalities, the procedure is considered cosmetic.
3. **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.

Based upon the above definitions, surgery of the upper eyelids is reconstructive when it provides functional vision and/or visual field benefits or improves the functioning of a malformed or degenerated body member, but cosmetic when done to enhance aesthetic appearance. The goal of functional restorative surgery is to restore significant function to a structure that has been altered by trauma, infection, inflammation, degeneration (e.g., from aging), neoplasia, or developmental errors.

Upper blepharoplasty and/or repair of blepharoptosis may be considered functional in nature when excess upper eyelid tissue or the upper lid position produces functional complaints. Those functional complaints are usually related to visual field impairment in primary gaze and/or down gaze (e.g., reading position). The visual impairment is commonly related to a lower than normal position of the eyelid relative to the pupil and/or to excess skin that hangs over the edge of the eyelid. Upper blepharoplasty may also be indicated for chronic dermatitis due to redundant skin and for patients with an anophthalmic socket who are experiencing prosthesis difficulties. Brow ptosis may also produce or contribute to functional visual field impairment. Either or both of these procedures may be required in

some situations when a blepharoplasty would not result in a satisfactory functional repair. Similarly, surgery of the lower eyelids is reconstructive when poor eyelid tone (with or without entropion or ectropion) causes dysfunction of the "lacrimal pump," lid retraction, and/or exposure keratoconjunctivitis that often results in epiphora (tearing).

The following are terms used to describe conditions which may require repair of the eyelids(s):

1. **Dermatochalasis:** excess skin with loss of elasticity that is usually the result of the aging process.
2. **Blepharochalasis:** excess skin associated with chronic recurrent eyelid edema that physically stretches the skin.
3. **Blepharoptosis:** drooping of the upper eyelid which relates to the position of the eyelid margin with respect to the eyeball and visual axis.
4. **Pseudoptosis:** "false ptosis," for the purposes of this policy, describes the specific circumstance when the eyelid margin is usually in an appropriate anatomic position with respect to the eyeball and visual axis but the amount of excessive skin from dermatochalasis or blepharochalasis is so great as to overhang the eyelid margin and create its own ptosis. Other causes of pseudoptosis, such as hypotropia and globe malposition, are managed differently and do not apply to this policy. Pseudoptosis resulting from insufficient posterior support of the eyelid, as in phthisis bulbi, microphthalmos, congenital or acquired anophthalmos, or enophthalmos is often correctable by prosthesis modification when a prosthesis is present, although persistent ptosis may be corrected by surgical ptosis repair.
5. **Brow Ptosis:** 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.
6. **Horizontal Eyelid Laxity:** poor eyelid tone, usually a result of the aging process, that causes (1) lid retraction without frank ectropion formation but with corneal exposure and irritation (foreign body sensation) and (2) dysfunction of the eyelid "lacrimal pump," both of which result in symptomatic tearing (epiphora).

Indications and Limitations:

The conditions listed under "2" and "3" below are generally considered reconstructive and not subject to the medical review of conditions listed under "1" which have the potential of being considered cosmetic
Blepharoplasty may be considered reconstructive when performed for one of the following conditions that may affect both upper and lower eyelids.

- To correct visual impairment caused by:
    - Dermatochalasis, including symptomatic redundant skin weighing down on the upper eyelashes (i.e., pseudoptosis) and surgically induced dermatochalasis after ptosis repair.
    - Blepharochalasis.
    - Blepharoptosis, including dehiscence of the aponeurosis of the levator palpebrae superioris muscle after trauma or cataract extraction, causing ptosis that may obstruct the superior visual field as well as the visual axis in downgaze (reading position).
    - Brow ptosis.
      It is recognized that brow ptosis repair, in addition to blepharoplasty and/or blepharoptosis repair, may be necessary in some cases to provide an adequate functional result.

  Any procedure(s) involving blepharoplasty and billed to this contractor must be supported by documented patient complaints which justify functional surgery. This documentation must address the signs and symptoms commonly found in association with ptosis, pseudoptosis, blepharochalasis and/or dermatochalasis. These include (but are not limited to):
    - Significant interference with vision or superior or lateral visual field, (e.g., difficulty seeing objects approaching from the periphery);
    - Difficulty reading due to superior visual field loss; or,

- Looking through the eyelashes or seeing the upper eyelid skin.

The visual fields should demonstrate a significant loss of superior visual field and potential correction of the visual field by the proposed procedures(s). A minimum 12 degree or 30 percent loss of upper field of vision with upper lid skin and/or upper lid margin in repose and elevated (by taping of the lid) to demonstrate potential correction by the proposed procedure or procedures is required. Photographs may be used to demonstrate the eyelid abnormality(ies) necessitating the procedures(s), but are not required. (Photography for purposes of documentation is not seperately reportable or reimbursed.) (Please see "Documentation Requirements.")

Please note that in the case of prosthetic difficulties associated with an anophthalmic, microphthalmic, or enophthalmic socket, subjective complaints, examination findings (signs), and failure of prosthesis modification (when indicated) must be documented, along with photographic documentation demonstrating the contribution of one of the above mentioned orbital and/or globe abnormalities as they relate to the abnormal upper and/or lower eyelid position and intolerance of prosthesis wear. (Please see "Documentation Requirements.")

- Repair of anatomical or pathological defects, including those caused by disease (including thyroid dysfunction and cranial nerve palsies), trauma, or tumor-ablative surgery. Surgery is performed to reconstruct the normal structure of the eyelid, using local or distant tissue. Reconstruction may be necessary to protect the eye and/or improve visual function. Conditions that may require blepharoplasty, ptosis repair, ectropion repair, or entropion repair are:
  - Ectropion and entropion
  - Epiblepharon
  - Post-traumatic defects of the eyelid
  - Post-surgical defects after excision of neoplasm(s)
  - Lagophthalmos
  - Congenital lagophthalmos
  - Congenital ectropion, entropion
  - Congenital ptosis
  - Lid retraction or lag (due to horizontal lower eyelid laxity without ectropion or entropion, causing exposure keratopathy and/or epiphora; due to horizontal upper eyelid laxity, causing floppy eyelid syndrome; or due to orbital thyroid disease).
  - Chronic symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin.

  The medical record must contain documented patient complaints and pertinent examination findings to justify the medical necessity for functional, restorative procedures(s) for the treatment of any of the above conditions. (Please see "Documentation Requirements.") (Photography for purposes of documentation is not separately reportable or reimbursed.)
- Relief of eye symptoms associated with blepharospasm. Primary essential (idiopathic) blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms the peri-ocular facial muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated, a blepharoplasty combined with limited myectomy may be necessary.

  Patient complaints and relevant medical history (e.g., failure to respond to botulinum toxin therapy, botulinum toxin therapy is contraindicated, etc.) must be documented and available upon request. Please see "Documentation Requirements."

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

Sources of Information

This bibliography presents those sources that were obtained during the development of this policy. CGS is not responsible for the continuing viability of Web site addresses listed below.

Aetna Clinical Policy Bulletin: Ptosis Surgery. Available at http://www.aetna.com/cpb/medical/ data/1_33/0084.html. Accessed 07/23/2007.

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers. Blepharoplasty. Available at http://www.plasticsurgery.org/medical_professionals/health_policy/recommended-insurance-coverage-criteria-papers.cfm. Accessed 07/25/2007.

American Society of Plastic Surgeons. Practice Parameter for Blepharoplasty. Available at http://www.plasticsurgery.org/medical_professionals/health_policy/Practice-Parameters.cfm. Accessed 07/25/2007.

Carrier Advisory Committee.

Other Medicare contractors' Local Coverage Determinations.

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
11/02/2023	R18	R17 Revision Effective: 11/02/2023 Revision Explanation: Annual review, no changes 10/27/2023: At this time 21st Century Cures Act will apply 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 policy.	• Other (Annual Review)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
10/27/2022	R17	R16 Revision Effective: 10/27/2022 Revision Explanation: Annual review, no changes 10/21/2022: At this time 21st Century Cures Act will apply 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 policy.	• Other (Annual Review)
10/21/2021	R16	R15 Revision Effective: 10/21/2021 Revision Explanation: Annual review, no changes 10/15/2021 :*At this time 21st Century Cures Act will apply 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 policy.*	• Other (Annual Review)
11/07/2019	R15	R14 Revision Effective: N/A Revision Explanation: Annual review, no changes 10/21/2020 :*At this time 21st Century Cures Act will apply 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 policy.*	• Other (Annual Review)
11/07/2019	R14	Annual Review	• Other (R13 Revision Effective: 11-07-2019 Revision Explanation: Updated article text with other comments from

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
			Coverage Indications, Limitations and/or Medical Necessity and Associated Information based on TDL 190550. Added details from to billing and coding article #A56439. 10/30/2019:At this time 21st Century Cures Act will apply 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 policy.)
09/19/2019	R13	R12 Revision Effective: 09/19/2019 Revision Explanation: Converted policy into new policy template that no longer includes coding section based on CR 10901. 09/19/2019:*At this time 21st Century Cures Act will apply 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 policy.*	• Revisions Due To Code Removal
03/28/2019	R12	R11 Revision Effective: 03/28/2019 Revision Explanation: Correction to the Billing and Coding Article. Added Group 2 ICD Codes for codes that may be considered as cosmetic. Attached article to the policy. 03/25/2019:*At this time 21st Century Cures Act will apply 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*	• Other (Revisions due to listing of detailed Group 2 codes)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		applicable as noted in this policy.	
10/01/2018	R11	R10 Revision Effective: 03/28/2019 Revision Explanation: Removed all billing and coding details from policy into related Billing and Coding article. Coding information was removed based on CR10901. 03/22/2019:*At this time 21st Century Cures Act will apply 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 policy.*	• Other (Removed billing and coding details)
10/01/2018	R10	Revision #:R9 Revision effective: 10/01/2018 Revision Explanation: H02.156 and H02.159 were left out of ICD-10 list in error during the annual ICD-10 update so added as indicated in revision 7. *(11/02/2018: At this time 21st Century Cures Act will apply 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 policy.*	• Typographical Error
10/01/2018	R9	Revision #:R7 Revision effective: N/A Revision Explanation: Annual review no changes made. *(10/30/2018: At this time 21st Century Cures Act will*	• Other (Annual Review)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		apply 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 policy.	
10/01/2018	R8	Revision #:R7 Revision effective: 10/01/2018 Revision Explanation: During the annual ICd-10 update the following codes were deleted: C44.102, C44.109, C44.112, C44.119, C44.122, C44.129, C44.192, C44.199, D04.11, D04.12, D22.11, D22.12, D23.11, D23.12 and G51.3. The following ICD-10 codes replaced the codes deleted from group 1: C44.1021, C44.1022, C44.1091, C44.1092, C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.131, C44.1321, C44.1322, C44.1391, C44.1392, C44.1921, C44.1922, C44.1991, C44.1992, D04.111, D04.112, D04.121, D04.122, D22.111, D2.2112, D22.121, D22.122, D23.111, D23.112, D23.121, D23.122, G51.31, G51.32, and G51.33. These codes were added as they are new for 2019 from the annual review: H01.00A, H01.00B, H01.01A, H01.01B, H01.02A, H01.02B, H02.151, H02.152, H02.154, H02.155, H02.156, H02.159, H02.20A, H02.20B, H02.20C, H02.21A, H02.21B, H02.21C, H02.22A, H02.22B, H02.22C, H02.23A, H02.23B, H02.23C, H02.881, H02.882, H02.884, H02.885, H02.88A, and H02.88B *09/19/2018: At this time 21st Century Cures Act will apply 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 policy.*	• Revisions Due To ICD-10-CM Code Changes
10/01/2015	R7	Revision #:R6 Revision effective: N/A Revision Explanation: Annual review no changes made.	• Other (Annual review)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		DATE (10/30/2017: At this time 21st Century Cures Act will apply 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 policy.	
10/01/2015	R6	Revision #:R5 Revision effective: N/A Revision Explanation: annual review no changes made	• Other (Annual Review)
10/01/2015	R5	Revision #:R4 Revision effective: N/A Revision Explanation: annual review no changes made	• Other (Annual Review)
10/01/2015	R4	Revision #:R2 Revision effective: N/A Revision Explanation: Accepted code descriptions changes for revenue codes.	• Other (revenue code description changes)
10/01/2015	R3	Revision #:R2 Revision effective: N/A Revision Explanation: Attached the updated blepharoplasty fact sheet.	• Provider Education/Guidance
10/01/2015	R2	Revision #:R2 Revision effective: N/A Revision Explanation: Attached the blepharoplasty fact sheet.	• Provider Education/Guidance
10/01/2015	R1	R1 Revision effective: 10/01/2014 Revision Explanation: Remove ICD-9 verbiage in covered ICD-10 lists.	• Provider Education/Guidance

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A56439 - Billing and Coding: Blepharoplasty

Related National Coverage Documents

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
10/27/2023	11/02/2023 - N/A	Currently in Effect (This Version)
10/21/2022	10/27/2022 - 11/01/2023	Superseded
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

N/A