Clinical Policy Title: Blepharoplasty

Clinical Policy Number: 10.03.01

Effective Date: July 1, 2013
Initial Review Date: June 19, 2013
Most Recent Review Date: June 15, 2016
Next Review Date: June 2017

ABOUT THIS POLICY: AmeriHealth Caritas Northeast has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Northeast’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by AmeriHealth Caritas Northeast when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Northeast’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Northeast’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Northeast will update its clinical policies as necessary. AmeriHealth Caritas Northeast’s clinical policies are not guarantees of payment.

Coverage policy

AmeriHealth Caritas Northeast considers the use of blepharoplasty to be clinically proven and, therefore, medically necessary when the following criteria are met:

<table>
<thead>
<tr>
<th>Criteria for medical necessity</th>
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</thead>
<tbody>
<tr>
<td><strong>Upper eyelid reconstructive blepharoplasty</strong> (current procedural terminology [CPT] codes 15822, 15823) is considered medically necessary for correction of functional visual impairment due to any of the following indications:</td>
</tr>
<tr>
<td>o Dermatochalasis, blepharochalasis or blepharoptosis with visual field impairment whether in primary gaze or down-gaze reading position.</td>
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<tr>
<td>o Ptsosis or prosthesis difficulties in an anophthalmic socket.</td>
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<td>o Epiphora (i.e., excessive tearing) due to ectropion and/or punctual eversion.</td>
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<tr>
<td>o Painful blepharospasm when debilitating and other treatments have failed or are contraindicated (i.e., an injection of botulinum toxin A); an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary.</td>
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<td>o Orbital sequelae of thyroid disease or nerve palsy (e.g., exposure keratitis).</td>
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<tr>
<td>• Lower lid blepharoplasty (CPT codes 15820 and 15821) is considered medically necessary for correction of functional visual impairment due to any of the following indications:</td>
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<td>• Combination of blepharoplasty, blepharoptosis repair and/or brow lift is considered medically necessary when the medical necessity criteria for each procedure are met and both of the following additional criteria are met:</td>
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</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Required documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Must meet requirements from sections A, B and C below)</td>
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</tbody>
</table>

A. Patient signs and symptoms which justify blepharoplasty may include any of the following: | |
| o | Interference with vision or visual field, related to activities such as, difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue. |
| o | Chronic eyelid dermatitis due to redundant skin. |
| o | Difficulty wearing prosthesis. |
| o | Chronic blepharitis. |

B. Photographs and medical documentation of indications causing malpositioning of the eyelid(s). Also may include:
Required documentation
(Must meet requirements from sections A, B and C below)

- Margin reflex distance (MRD) of ≤ 2.5 mm; the upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.
- A palpebral fissure height on down-gaze of ≤ 1 mm. The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated.
- The presence of Herring’s effect meeting one of the above two criteria.

C. Visual fields testing must do all of the following:
- Demonstrate a minimum 12° 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.
- Meet accepted quality standards, whether they are performed by Goldmann technique or by use of a standardized automated technique.
- Visual field testing is not necessary for:
  1. Patients with an anophthalmic socket who is experiencing ptosis or difficulty with their prosthesis.
  2. Patients who are not capable of performing the testing, for example:
     a. Child 12 years old or under.
     b. Patient with mental retardation or some other severe neurologic disease.
     c. Coverage will be determined on the basis of clinical notes documenting eyelid abnormality, MRD-1 of ≤ 2.5 mm and photographs confirming the eyelid abnormality.

Limitations:

- All other uses of blepharoplasty are not medically necessary. AmeriHealth Caritas Northeast considers blepharoplasty, performed solely to enhance a patient’s appearance, in the absence of any signs or symptoms of functional abnormalities, to be not medically necessary for individuals who do not meet the above criteria.

NOTE: The following codes are not included in the Medicaid medical fee schedule in Pennsylvania

67900 - Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Alternative covered services:

Evaluation by network primary care physicians and eye care professionals.
**Background**

Blepharoplasty is a procedure that reconstructs eyelid deformities and improves abnormal function and/or enhances appearance of the eyelids. It involves the excision of excess skin, muscle or fat from the upper and lower eyelids and may include rearrangement of the structures with the eyelids and/or tissues of the cheek, forehead and nasal areas using local or distant tissue grafts to reconstruct the normal structure of the eyelid. Advances in minimally invasive techniques, including laser-assisted applications, may allow for greater patient comfort, fewer complications and more rapid recovery (ASPS 2007).

Blepharoplasty is considered restorative and, therefore, medically necessary when it is performed to restore significant function to the eyelid that has been altered by trauma, infection, inflammation, degeneration (e.g., from aging), neoplasia or developmental defects. Cosmetic blepharoplasty is performed to improve a patient’s appearance in the absence of any signs and/or symptoms of functional abnormalities and is not considered medically necessary (ASPS 2007).

Patients who may require restorative blepharoplasty present with a variety of symptoms or combination of symptoms, including edema, visual field defects, hypertrophy of the obicularis oculi, conjunctival inflammation, keratitis, malar festoons, blepharospasm, blepharochalasis, dermatochalasis, lagophthalmos, protrusion of orbital fat, eyelid ptosis and eyebrow ptosis. To assess for ophthalmic and periocular disease, surgeons look for current illnesses, dry eye, allergies, history of eyelid swelling, thyroid disease, heart failure and bleeding tendencies in the medical history.

Contraindications to blepharoplasty include:

- Underlying conditions, such as Grave’s disease, that may be related to the development of conditions that cause visual field loss, as the excessive eye bulk that may result from these conditions will typically resolve after adequate medical treatment, obviating the need for surgical intervention.
- Untreated thyroid disease.
- Conditions associated with dry eye syndrome (e.g., collagen vascular disorders, lupus, rheumatoid arthritis or Sjögren’s syndrome).
- Active eye disease.

Surgical planning involves several factors, including whether upper or lower eyelids or both will be surgically treated and the extent of surgical involvement, which technique(s) to use, and any adjunctive procedures to be performed to restore more complete function or facial expression and for aesthetic improvement. Adjunctive procedures include brow ptosis repair (internal trans-blepharoplasty, direct, coronal or endoscopic), ptosis repair, lacrimal gland suspension, eyelid lengthening and lower eyelid tightening or lateral canthopexy (Oestreicher 2012).

Documentation of medical necessity should include indications for reconstructive blepharoplasty, the severity of the symptoms of eyelid deformities and/or the impact on health-related quality of life. If the patient is experiencing visual impairment, formal visual field testing by an optometrist or ophthalmologist may be needed. A complete eye exam may also be appropriate in certain cases. Other diagnostic studies, as clinically indicated, should be performed and noted, such as Schirmer’s test (tearing or dry eye test),
CBC/BMP, bleeding and clotting studies, and cardiac evaluation. Preoperative photographs may be taken to meet the requirements of both the insurers and surgeons. Additional photographs may include upward and downward gaze as well as oblique views (ASPS 2007).

Visual field testing is used to measure the severity of eyelid and brow defects. The most significant visual field measurement associated with determining the need for blepharoplasty is the superior visual field. The normal extent of the superior visual field is approximately 55° to 60° at the 90° meridian. Impairment of the superior visual field can range from 20 percent, considered mild ptosis, to 64 percent in more severe cases where the eyelid crosses the middle of the pupil. In general, mild to moderate impairment of the visual field is of no clinical significance and requires no intervention. When obstruction of the visual field becomes severe or significant enough to interfere with the patient’s ability to perform activities of daily living, surgical intervention may be warranted. Generally accepted criteria for clinically significant visual field impairment are a minimum of at least 20° or 30 percent loss of upper field 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 (Oestreicher 2012, ASPS 2007a, ASPS 2007b).

While blepharoplasty is a widely practiced surgical procedure, the potential for complications exists due to the complex structure and function of the eyelids. Complications range from minor to serious and may be perceived differently between patient and surgeon (Morax 2006). These include superficial ecchymosis and hematoma, wound dehiscence, scar abnormalities, upper eyelid overcorrection, lower eyelid overcorrection and retraction, asymmetry, ptosis, epiphora and ocular discomfort, diplopia, ocular injury, orbital hemorrhage and vision loss, pigmentary abnormalities, and CO₂ laser resurfacing. Most complications can be avoided or mitigated through appropriate patient selection, presurgical planning and choice of surgical technique, and most can be treated effectively (Oestreicher 2012).

Table 1 summarizes the evidence from systematic reviews for blepharoplasty. A Cochrane review of involutional entropion techniques of the lower eyelid identified one randomized controlled trial (RCT) that found the combination of horizontal and vertical eyelid tightening with everting sutures and lateral tarsal strip was highly curative for entropion compared to vertical tightening with everting sutures alone in an elderly population (Borboridis 2011). The authors also noted that the findings were supported by many good-quality uncontrolled studies on specific surgical procedures that did not meet criteria for inclusion.

Chang et al. conducted a systematic review of procedures commonly involving blepharoplasty and involutional ptosis repair of the upper eyelid (Chang 2012). They found insufficient evidence from prospective RCTs comparing either the efficacy or complication rates among upper eyelid involutional techniques. The authors emphasized the need for a systematic review of observational studies to assess the complication rates and outcomes associated with the different surgical techniques.

While no economic analyses for blepharoplasty were identified, studies that capture patient-centered benefits of blepharoplasty can be used to inform future economic studies. Smith et al. conducted a cross-sectional study to measure self-reported patient benefit derived from four common oculoplastic procedures using a global quality-of-life scale called the Glasgow benefit inventory (GBI) (Smith 2012). The GBI generates a scale from -100 (maximal detriment) through zero (no change) to +100 (maximal benefit). The total GBI scores for entropion repairs (n = 66), ptosis repairs (n = 50), ectropion repairs (n = 41), and
external dacryocystorhinostomies (DCR) (n = 41) were: +25.25 (95 percent CI 20.00-30.50, P < 0.001), +24.89 (95 percent CI 20.04-29.73, P < 0.001), +17.68 (95 percent CI 9.46-25.91, P < 0.001), and +32.25 (95 percent CI 21.47-43.03, P <0.001), respectively, demonstrating a statistically significant benefit from all procedures.

The evidence for the use of blepharoplasty is derived largely from retrospective surgical case series with inherent high bias, and few RCTs or other study designs that compare techniques directly exist to permit conclusions regarding the relative safety and effectiveness of individual techniques or optimal candidate criteria. Therefore, existing coverage policies for blepharoplasty are based on consensus-based professional society practice guidelines, case series and a consensus of expert opinion.

Study types consulted in preparing this policy: Systematic reviews, which synthesize results qualitatively or pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies, use predetermined transparent methods to minimize bias, effectively applying scientific methods to a review to enhance the reliability of the findings; thus, they are rated highest in evidence grading hierarchies. Economic analyses (e.g., cost-effectiveness, benefit or utility studies) that report both costs and outcomes ideally based on randomized controlled trials, but excluding simple cost studies, also rank near the top of evidence hierarchies. Two available systematic reviews for blepharoplasty and no economic analyses were identified.

**Searches**

AmeriHealth Caritas Northeast searched PubMed and the following databases:
- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

Search terms were: "blepharoplasty" [MeSH].

We conducted searches on May 24, 2016.

We included:
- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews**.
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.
**Findings**

AmeriHealth Caritas Northeast identified only a small number of studies or analyses to include in the update. Three (3) 2015 publications by Pool and colleagues were controlled studies of comparing outcomes of varying methods used in surgery. Findings showed that 1) fewer abscesses occurred when sutures are started at the medial side of the upper blepharoplasty wound; 2) pain scores and degree of edema/erythema and hematoma lower when lidocaine uses as an anesthetic; and 3) eyelids cooled right after surgery with an ice pack results in less pain (vs. uncooled) after 1 day, but not earlier or later.

No changes to the original policy are warranted.

**Policy updates:**

None.

**Summary of clinical evidence:**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
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</table>
| Pool, Krabbe, et al. (2015) | Key points:  
Comparison of externally vs. internally sutured upper eyelids during blepharoplasty:  
- Level I Randomized Controlled Trial (RCT), 30 patients.  
- Reviewed abscesses/wound inflammation using both techniques, a week after surgery.  
- 40.0% vs. 13.3% abscess rates for externally vs. internally sutured patients.  
- Recommendation that sutures be started at the medial side of the upper blepharoplasty wound, resulting in less inflammation and fewer suture abscesses. |
| Pool, Struys et al. (2015) | Key points:  
Comparison of lidocaine with epinephrine vs. prilocaine with felypressin injected in eyelids:  
- Level II randomized, double-blinded crossover study.  
- 40 patients had one eyelid each injected with the two types of anesthesia.  
- Pain scores and degree of edema/erythema, hematoma before discharge lower in the lidocaine group.  
- No difference in need for reinjection during operation. |
| Pool, van Exsel et al. (2015) | Key points:  
Investigation of efficacy of eyelid cooling to reduce post-op pain, edema, erythema, and hematoma after blepharoplasty:  
- RCT with 38 patients undergoing bilateral blepharoplasty.  
- One eyelid cooled with an ice pack, one left uncooled, evaluated up to two months.  
- No difference in pain between groups.  
- Pain lower in cooled group one day post-op, but not for any other time period. |
| Kiang et al (2014) | Key points:  
Comparison of muscle-sparing vs. conventional blepharoplasty: |
22 patients evaluated up to six (6) months post-op. No difference in groups in aesthetic outcomes. Muscle-sparing group had fewer complications of sluggish eyelid closure, lagophthalmos, and dry-eye disease.

Chang (2012) **Key points:**

**Involutional upper eyelid ptosis repair techniques:**
- Systematic review — No prospective RCT identified. Systematic review of available observational studies is needed to determine efficacy and complication rates between different involutional lid ptosis repair techniques.

Borboridis (2011) **Key points:**

**Involutional entropion techniques:**
- Cochrane review — 1 RCT of 63 participants included with eight lost to follow-up.
- Combination of horizontal and vertical lower eyelid tightening with everting sutures and lateral tarsal strip is highly curative for entropion compared to vertical tightening with everting sutures alone.
- Authors noted that results were supported by many good-quality uncontrolled studies on specific surgical procedures, but the studies did not meet criteria for inclusion.

**CMS policies:**

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Coverage indications, limitations, and/or medical necessity:</th>
</tr>
</thead>
</table>
| Medicare | **A.** Upper eyelid blepharoplasty (CPT 15822 and 15823) procedures will be considered medically necessary when performed as functional/reconstructive surgery to correct:  
  1. Visual impairment with near or far vision due to dermatochalasis, blepharochalasis or blepharoptosis; or visual field impairment whether in primary gaze or down-gaze reading position; or a decrease in peripheral vision and/or upper field vision.
  2. Symptomatic redundant skin weighing down on upper lashes.
  3. Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin.
  4. Ptosis or prosthesis difficulties in an anophthalmic socket.  
**B.** Lower lid blepharoplasty (CPT 15820 and 15821) is considered medically necessary when documentation:  
  • Supports horizontal lower eyelid laxity of medial and lateral canthus resulting in dacryostenosis and infection.
  • Supports significant lower eyelid edema.
  • Reveals that glasses rest upon the lower eyelid tissues and cause lower eyelid ectropion as a result of the weight of the glasses and weight of the tissue.
  • Payment may be considered on an individual consideration basis when supportive documentation (e.g., the patient's chief complaint and operative report) is included as part of the patient's medical record to demonstrate that the procedure is medically necessary for reconstructive reasons.  
**C.** Relief of eye symptoms associated with blepharospasm (333.81). Primary essential idiopathic blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated (i.e., an injection of botulinum toxin A), an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary. |
Documentation of the following criteria (A, B, C and D, if applicable) must be met to establish medical necessity:

A. Patient signs and symptoms that justify functional surgery may include:
   1. Interference with vision or visual field, related to activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin and brow fatigue.
   2. Chronic eyelid dermatitis due to redundant skin.
   3. Difficulty wearing prosthesis.
   4. Chronic blepharitis.

B. Photographs and medical documentation of one or more of the following:
   1. Frontal photos are needed to demonstrate redundant skin on the upper eyelids.
   2. Upper eyelid skin resting on the eyelashes or over eyelid margin.
   3. Upper eyelid indicates the presence of dermatitis, or upper eyelid dermatitis secondary to redundant skin.
   4. Dermatochalasis (ICD-9 code 374.87).
   5. The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmia socket.
   6. Also may include:
      a. MRD of 2.5 mm or less; the upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.
      b. A palpebral fissure height on down-gaze of 1 mm or less. The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated.
      c. The presence of Herring's effect meeting one of the above two criteria. (Herring's law is one of equal innervation to both upper eyelids and is considered in the documentation to perform bilateral ptosis in which the position of one upper eyelid has marginal criteria and the other eyelid has good supportive documentation for ptosis surgery. In these cases, the surgeon can lift the more ptotic lid with tape or instillation of phenylepherine drops into the superior fornix. If the less ptotic lid then drops downward according to Herring's law to the point of an MRD of 2.5 mm or less or a down-gaze MRD of 1.5 or less or a palpebral fissure width on down-gaze of 1 mm or less, then the less ptotic lid would be considered for surgical correction.)

C. Visual fields testing recorded to:
   1. Demonstrate 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. Visually significant brow ptosis may be documented by visual field testing with the brow elevated demonstrating a difference of 12° or more or 30 percent superior visual field difference.
   2. Visual fields need to meet accepted quality standards, whether they are performed by Goldmann technique or by use of a standardized automated technique.
   3. Visual fields are not necessary for patients with an anophthalmic socket who are experiencing ptosis of difficulty with their prosthesis.

D. If a combination of a blepharoplasty and another repair (e.g., ptosis repair or brow lift) are planned, both must be individually documented.

Limitations:

1. Blepharoplasty done for cosmetic purposes, not meeting the criteria of the functional
visual impairment parameters previously listed, will be denied.

2. When the physician has determined that the patient requires a bilateral blepharoplasty, bilateral blepharoptosis repair or bilateral brow ptosis repair, it is expected that the procedures will be performed on the same date of service. Bilateral procedures performed on different dates of service require documentation in the patient’s medical record to support the medical necessity of performing these procedures on different dates of service.

3. External ocular photography (92285) is not payable when used to support the need for blepharoplasty, blepharoptosis or brow ptosis.

Glossary

**Blepharoplasty** — A procedure that reconstructs eyelid deformities, improves abnormal function and/or enhances appearance of the eyelids. Cosmetic blepharoplasty can improve a patient’s appearance in the absence of any signs and/or symptoms of functional abnormalities. Reconstructive blepharoplasty can restore function by transforming abnormal eyelid structures to a more normal state.

**Blepharochalasis** — A condition in which there is a redundancy of eyelid skin.

**Dermatochalasis** — Characterized by deficient elastic fibers of the skin, which may hang in folds. Skin redundancy and/or muscle laxity involving the eyelids that can impair vision.

**Ptosis** — Occurs when the eyelid droops more than is considered normal, potentially impairing vision. Ptosis is usually categorized as either “true ptosis,” an intrinsic disturbance of the eyelid structures, or as a “pseudoptosis,” a lack of normal eyelid support or the presence of excess lid tissue that “hoods” the eye, restricting the upward gaze and blocking the peripheral and/or forward vision.

Related policies:

AmeriHealth Caritas Northeast Utilization Management program description.

References

**Professional society guidelines/other:**


**Peer-reviewed references:**


**Clinical trials:**

Searched clinicaltrials.gov on May 24, 2016, using term “blepharoplasty” | Open Studies. Thirteen (13) studies found, two (2) relevant.


CMS National Coverage Determinations (NCDs):

No NCDs identified as of the writing of this policy.

Local Coverage Determinations (LCDs):

Medicare coverage database search on May 24, 2016, for final LCDs using the keyword “blepharoplasty” in the entire document.

L33994 Blepharoplasty (CGS Administrators LLC)
L34194 Blepharoplasty, Eyelid Surgery and Brow Lift (Noridian Healthcare Solutions LLC)
L36279 Blepharoplasty, Eyelid Surgery and Brow Lift (Noridian Healthcare Solutions LLC)
L36281 Blepharoplasty, Eyelid Surgery and Brow Lift (Noridian Healthcare Solutions LLC)
L36286 Blepharoplasty, Eyelid Surgery and Brow Lift (Noridian Healthcare Solutions LLC)
L34528 Blepharoplasty, Blepharoptosis and Brow Lift (Wisconsin Physicians Service Insurance Corporation)
L33765 Blepharoplasty, Eyelid Surgery and Brow Lift (Palmetto GBA)
L34411 Blepharoplasty, Eyelid Surgery and Brow Lift (Palmetto GBA)
L34286 Surgery: Blepharoplasty (Cahaba Government Benefit Administrators ® LLC)
L35004 Surgery: Blepharoplasty (Novitas Solutions, Inc.)

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
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<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid; with extensive, herniated fat pad</td>
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<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
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<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid; with excessive skin weighting down lid</td>
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<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
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<tr>
<td>ICD-10 Code</td>
<td>Description</td>
<td>Comment</td>
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<tr>
<td>G24.5</td>
<td>Blepharospasm</td>
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<tr>
<td>H02.101-H02.109</td>
<td>Unspecified ectropion of eyelid</td>
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<tr>
<td>H02.111-H02.119</td>
<td>Cicatricial ectropion of eyelid</td>
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<tr>
<td>H02.121-H02.129</td>
<td>Mechanical ectropion of eyelid</td>
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<tr>
<td>H02.131-H02.139</td>
<td>Senile ectropion of eyelid</td>
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<tr>
<td>H02.141-H02.149</td>
<td>Spastic ectropion of eyelid</td>
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<tr>
<td>H02.30-H02.36</td>
<td>Blepharchalasis eyelid</td>
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<tr>
<td>H02.401-H02.409</td>
<td>Unspecified ptosis of eyelid</td>
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<tr>
<td>H02.411-H419</td>
<td>Mechanical ptosis of eyelid</td>
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<tr>
<td>H02.421-H02.429</td>
<td>Myogenic ptosis of eyelid</td>
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<tr>
<td>H02.431-H02.439</td>
<td>Paralytic ptosis of eyelid</td>
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<tr>
<td>H02.831-H02.839</td>
<td>Dermatochalasis of eyelid</td>
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<tr>
<td>HCPCS Level II</td>
<td>Description</td>
<td>Comment</td>
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<td>N/A</td>
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</table>

- **H16.211-H16.213**: Exposure keratoconjunctivitis
- **Q10.0-Q10.3**: Congenital ptosis