Medical Policy

Blepharoplasty, Blepharoptosis Repair, and Brow Lift

MEDICAL POLICY NUMBER: 101

Effective Date: 11/1/2025

Last Review Date: 8/2025

Next Annual Review: 8/2026

INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

Eye: Blepharoplasty, Blepharoptosis Repair, and Brow Lift: Guideline note 130

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Note: This policy does not address blepharoplasty, blepharoptosis, or brow lifts requested as gender affirming interventions. Please see the Policy Cross References Section below for the appropriate policy.

I. Upper eyelid blepharoplasty (CPT 15823) is considered **medically necessary** when the following criteria are met:

A. Documentation demonstrates the member's complaint of interference with daily visual tasks or visual field-related activities (e.g., reading, driving, etc.), and
B. Documentation shows visual obstruction due to overhanging skin resting on or depressing the lashes or eyelid margin, demonstrated by the following:
1. Either:
a. A peripheral visual field testing performed with the eyelid and brow in the resting position that documents a baseline superior visual field of 30 degrees or less from fixation and improvement of at least 12 degrees over baseline with eyelid and brow elevation. (See Policy Guidelines for Definition of Peripheral Visual Field Testing); or
b. A margin to reflex distance (MRD) less than or equal to 2 mm in primary position; and
2. Photographs documenting the obstruction include:
a. Good quality, color frontal upper face photograph, with the gaze in the primary position clearly showing corneal light reflex unless the ptotic tissue is so severe as to obscure the light reflex (demonstrating

severe ptosis and/or dermatochalasis), and
    b. **If needed** to further demonstrate overhanging excess skin as well as lash ptosis, oblique or lateral view photographs; and
    c. **If needed** in cases in which ptosis is worse in the down-gaze position, a frontal photograph with member looking in a down-gaze position.

II. Upper eyelid blepharoptosis (ptosis) repair (CPT 67901, 67902, 67903, 67904, 67906, 67908) is considered **medically necessary** when the following criteria are met:

A. Documentation demonstrates the member's complaint of interference with daily visual tasks or visual field-related activities (e.g., reading, driving, etc.), and
B. One of the following is documented:
    1. A margin to reflex distance (MRD) less than or equal to 2 mm in primary or downgaze (see Policy Guidelines for downgaze position); or
    2. The position of one upper eyelid, which initially appears not to meet criteria but becomes more ptotic with an MRD of 2 mm or less when the other, more ptotic eyelid is elevated (i.e. Hering's Law); and
C. Documentation of visual obstruction due to ptotic upper eyelid, demonstrated by the following:
    1. Peripheral visual field testing performed with the eyelid and brow in the resting position that documents a baseline superior visual field of 30 degrees or less from fixation and improvement of at least 12 degrees over baseline with eyelid and brow elevation. (See Policy Guidelines for Definition of Peripheral Visual Field Testing); and
    2. Photographs documenting the obstruction include:
        a. Good quality, color frontal upper face photograph, with the gaze in the primary position clearly showing corneal light reflex unless the ptotic tissue is so severe as to obscure the light reflex (demonstrating severe ptosis and/or dermatochalasis), and
        b. **If needed** to further demonstrate overhanging excess skin as well as lash ptosis, oblique or lateral view photographs; and
        c. **If needed** in cases in which ptosis is worse in the down-gaze position, a frontal photograph with member looking in a down-gaze position.

Note: For patients with equal innervation to both eyelids, if one eyelid meets criterion I. above, the less ptotic eyelid may also be repaired.

III. Repair of brow ptosis (CPT 67900) should be considered **medically necessary** when:
A. Documentation demonstrates brow ptosis contributes to skin fold overlap and/or blepharoptosis;
B. Photograph with brows elevated or taped up to a normal position to document the effect of brow ptosis
C. The ptosis meets the criteria outlined above for upper eyelid blepharoplasty and/or blepharoptosis (ptosis) surgery (Criteria I and II).

IV. Planned repair of both brow ptosis and blepharoptosis/overhanging skin may be considered **medically necessary** if criteria for all individual procedures are met.

V. Blepharoplasty, blepharoptosis repair, and repair or brow ptosis is considered **not medically necessary** when the corresponding criteria I, II, or III are not met.

VI. Lower eyelid blepharoplasty (CPT 15820, 15821) is considered **cosmetic** in the absence of a functional impairment.

Link to Evidence Summary

POLICY CROSS REFERENCES

- Cosmetic and Reconstructive Procedures, MP98
- Gender Affirming Surgical Interventions, MP32

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. All medical records and chart notes to include clinical documentation to support review including but not limited to the following:

- History
- Physical examination
- Treatment plan including whether surgery will be performed as multiple stages.
- If two (or more) surgeries are planned, each must be individually documented. This may (sometimes, but not necessarily) require multiple sets of photographs.
- Color photographs with detail as described in Policy Guidelines.
- Detailed description of all physical signs when relevant to criteria.
- If planned procedure is reconstructive in circumstances of congenital defects, developmental abnormalities, trauma, infection, tumors, documentation of patient complaint regarding impacts on their ability to perform tasks of daily living (or, in the absence of a specific complaint, a statement that the repair is needed to prevent anticipated future damage to ocular structures).

Daily Visual Tasks or Visual Field-Related Activities

Clinical notes should document patient complaints of visual impairment secondary to abnormal eyelid or brow position resulting in limitation of daily visual tasks or visual field-related activities such as reading, driving, difficulty seeing objects approaching from the periphery, or using a computer.

Patients might describe the need to manually elevate their eyelids to see and may experience a brow ache or headache from constant brow elevation, adopt a compensatory chin elevation, or bump their head on overhead objects. Patients with ptosis or dermatochalasis may also complain of seeing their own lashes or feeling them irritating the cornea. Children with ptosis may not have complaints concerning visual function.

Lower Eyelid Blepharoplasty

Lower eyelid blepharoplasty is almost never functional in nature and is reviewed per policy criteria as written, though usually does not meet criteria.

Examples of conditions that may require lower eyelid blepharoplasty include: Graves' disease, myxedema, nephrotic condition that are unresponsive to conservative medical management.

Notes on Unique Circumstances for Physical Signs

- If an anatomic abnormality of the eye (such as an eccentric or elongated pupil) makes the MRD either difficult to establish or meaningless for this purpose, it is expected the surgeon will include a statement outlining their rationale that an equivalent standard has been met.

- Visual fields are not required for children (17 years or younger) or other patients physically or mentally unable to perform visual field testing (e.g. intellectual disability, severe neurologic disease).

Photographs

- Photographs are required to support upper eyelid surgery as medically necessary.
- The physical signs must be clearly represented in photographs of the structures of interest and the photographs must be of good quality and of sufficient size and detail as to make those structures easily recognizable.
- The patient's head and the camera must be in parallel planes, not tilted so as not to distort the appearance of any relevant finding.
- Unless medial/lateral gaze is required to demonstrate a specific deficit, photos should be with gaze in the primary position, looking straight ahead.
- Oblique photos are only necessary if needed to better demonstrate a finding not clearly shown by other requested photos.
- Digital or film photographs are acceptable and may be submitted electronically where possible. Photographs must be identified with the member's name and the date.
- For Blepharoptosis Repair:
    - Photographs of both eyelids in the frontal (straight-ahead) position should demonstrate the MRD outlined in the criteria. If the eyelid obstructs the pupil, there is a clear-cut indication for surgery. (For reference, the colored part of the eye is about 11 mm in

diameter, so the distance between the light reflex and the lid would need to be about one fifth that distance or less for the MRD to be 2.0 mm or less.)
    - In the special case of documenting the need for bilateral surgery because of Herring's law, two photos are needed:
        - One showing both eyes of the patient at rest demonstrating the above MRD criterion in the more ptotic eye, and
        - Another showing both eyes of the patient with the more ptotic eyelid raised to a height restoring a normal visual field, resulting in increased ptosis (meeting the above MRD standard) in the less ptotic eye.
- Reviewers will assume the accepted average of 11 mm of corneal diameter to assess measurements in photographs. If a patient's corneal diameter deviates from this by more than 0.5 mm, this should be clearly documented in the record so appropriate adjustments can be made. Alternatively, an accurate millimeter ruler can be taped along the brow, on the cheek, or elsewhere in the photo (approximately in the corneal plane) to facilitate such measurements.
- For Upper Lid Blepharoplasty:
    - Photographs of the affected eyelid(s) in both frontal (straight ahead) and lateral (from the side) positions demonstrate the physical signs in the criteria. Oblique photos are only necessary if needed to better demonstrate a finding not clearly shown by frontal and lateral photos.
- For Brow Ptosis Repair:
    - One frontal (straight ahead) photograph should document drooping of a brow or brows and the appropriate other criteria. If the goal of the procedure is improvement of dermatochalasis, a second photograph should document such improvement by manual elevation of brow(s). If a single frontal photograph that includes the brow(s) would render other structures too small to evaluate, additional (overlapping to the degree possible) photos should be taken of needed structures to ensure all required criteria can be reasonably demonstrated and evaluated.
- If both a blepharoplasty and a ptosis repair are planned, both must be individually documented. This may (sometimes, but not necessarily) require two sets of photographs: showing an MRD of 2.0 mm or less (or basline superior visual field of 30 degrees or less from fixation) secondary to the redundant skin (and its correction by taping), AND an MRD of 2.0 mm or less secondary to the blepharoptosis.

<u>Ptosis Symptoms in Down-Gaze</u>

Some patients with involutional ptosis may only exhibit symptomatic visual field impairment in down-gaze. These patients often complain of difficulty walking while looking down, or the inability to read or work in the down-gaze position for long periods of time resulting in brow ache, fatigue, or having to manually elevate their eyelids. In cases in which the degree of ptosis in primary gaze does not initially meet inclusion criteria for functional ptosis surgery, but the patient complains of difficulty reading or completing other close work when looking down, the MRD should be measured and photographs taken in down-gaze. If the MRD in down-gaze measures 2 mm or less, functional ptosis surgery should be considered in order to improve visual function in these patients.

Blepharoplasty and blepharoptosis repair may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. They may be either functional/reconstructive or cosmetic. Upper blepharoplasty (removal of upper eyelid skin) and/or repair of blepharoptosis should be considered functional/reconstructive in nature when the upper lid position or overhanging skin is sufficiently low to produce functional complaints, usually related to visual field impairment whether in primary gaze or down-gaze reading position. Upper blepharoplasty may also be indicated for chronic dermatitis due to redundant skin. Another indication for blepharoptosis surgery is patients with an anophthalmic socket experiencing ptosis or prosthesis difficulties. A brow lift is a surgery that may be performed to correct brow ptosis (droop of the eyebrows), which can also produce or contribute to functional impairment.

Visual Field Test*:* Peripheral visual field testing performed with the eyelid and brow in the resting position that documents a baseline superior visual field of 30 degrees or less from fixation and improvement of at least 12 degrees over baseline with eyelid and brow elevation. Both manual, including Goldmann and tangent screen, and automated fields are acceptable. The measurement of a patient's superior visual field is defined as the lowest point seen at the vertical meridian. Visual fields are not required for children or other patients physically unable to perform visual field testing.

When visual field testing is performed, the forehead muscles must be completely relaxed, with the patient's eyelids and brows in their baseline resting position. The testing is repeated with the excess eyelid skin, ptotic eyelids, and/or ptotic brows elevated to normal anatomic position, thereby assessing superior or peripheral visual field loss due to eyelid skin or margin, or brow position. Unobstructed, the superior field normally measures approximately 45 to 50 degrees. An MRD of 2 mm corresponds to a superior visual field impairment of 12-15 degrees. Thus, a *baseline superior visual field of 30-35 degrees corresponds to an MRD of 2mm*. A superior visual field of 30 degrees or less that improves with eyelid and brow elevation corresponds to a functional superior visual field loss.

Figures

Figure 1. Goldmann (manual kinetic) ptosis field.

The solid line is with the lid at resting position and the dotted line with the lid elevated and taped. The baseline superior field is 20 degrees, and taping predicts a potential improvement of an additional 22 degrees.[1]

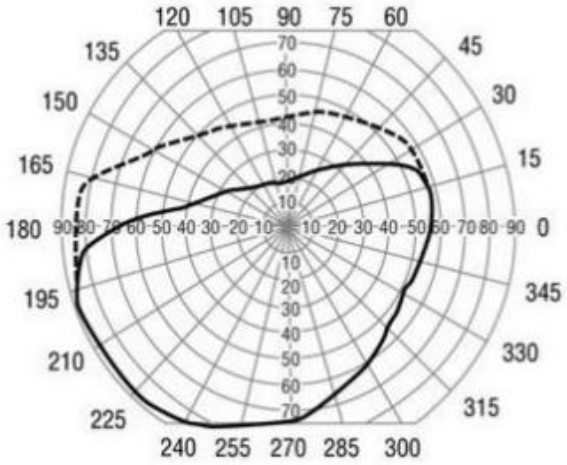
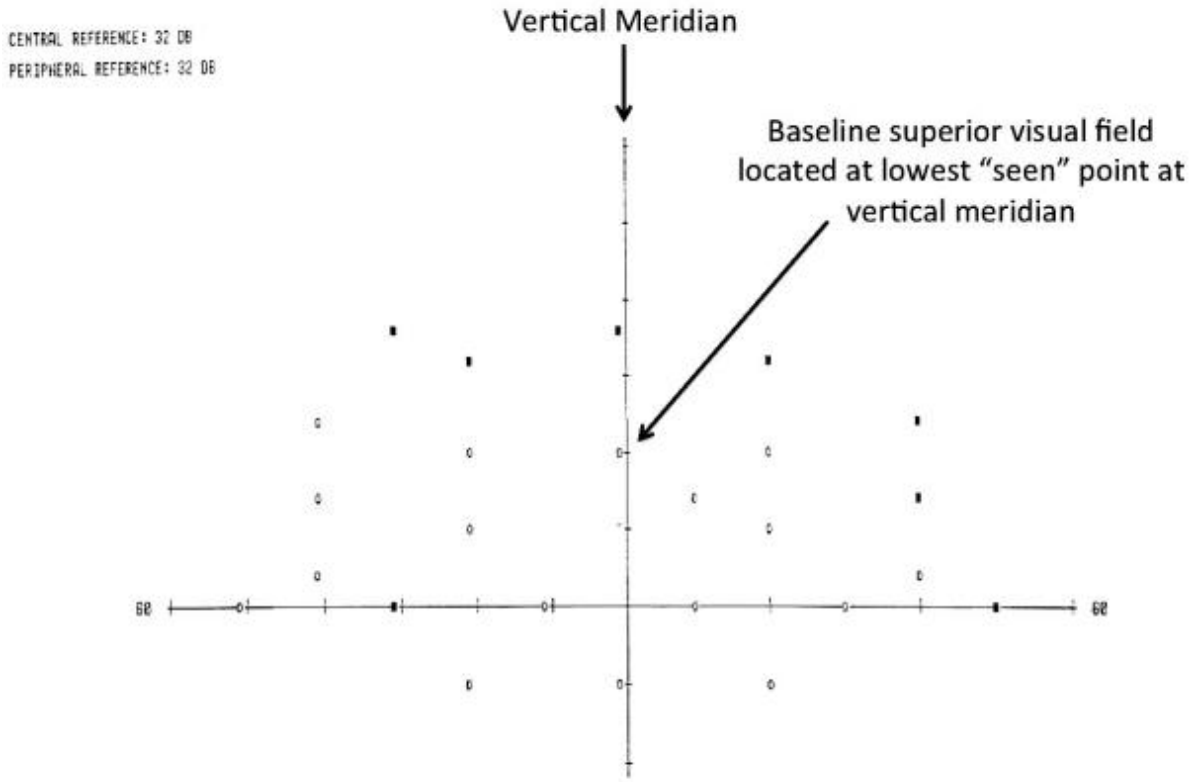


Figure 2. Automated visual field.

When interpreting automated lid fields, the baseline superior visual field is defined as the lowest "seen" point on the vertical meridian (arrow). For this patient, the baseline superior visual field is 20 degrees (hash marks located at 10 degree intervals). In automated fields in which there are no midline points, the two lowest "seen" points straddling the vertical meridian are averaged and used as the baseline.[1]



Definitions relevant to the policy criteria:

Blepharoptosis: drooping of the upper eyelid related to the position of the eyelid margin with respect to the visual axis

Blepharoplasty: removal of eyelid skin, fat, and or muscle

Blepharoptosis repair (also known as levator resection): restoring the eyelid margin to its normal anatomic position.

Blepharochalasis: excess skin associated with chronic recurrent eyelid edema that physically stretches the skin.

Brow ptosis: drooping of the eyebrows to such an extent that excess tissue is pushed into the upper eyelid that may cause mechanical blepharoptosis and/or dermatochalasis

Brow ptosis repair: restoring the eyebrow tissues to their normal anatomic position.

Dermatochalasis: excess skin with loss of elasticity that is usually the result of the aging process.

Ectropion: an outward turning of the eyelid margin.

Entropion: an inward turning of the eyelid margin and appendages such that the pilosebaceous unit and mucocutaneous junction are directed posterior towards the globe.

Trichiasis: a condition, resulting from the eye infection called trachoma, in which the eyelid turns inward and eyelashes rub against the eye, resulting in corneal scarring and loss of vision.

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. In these rare cases, an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary to properly treat symptoms.

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

CLINICAL EVIDENCE AND LITERATURE REVIEW

EVIDENCE REVIEW

- In 2011, Cahill and colleagues published a report for the American Academy of Ophthalmology (AAO) examining the functional indications for upper eyelid surgery. Their literature search identified 13 relevant case series that met inclusion criteria, each evaluating various surgical techniques for ptosis. One of these studies involved participants with "simulated ptosis" created using specialized contact lenses, while the rest focused on patients with actual ptosis. In the discussion section, the authors also referenced additional studies that were excluded from the formal literature search. These were included to illustrate the impact of ptosis on the superior peripheral visual field and formed the basis for the report's recommendations regarding visual field loss. These studies employed a range of perimetric methods to assess visual field impairment.The discussion also addressed the effects of ptosis on down-gaze, referencing several small studies not included in the initial literature review. These studies highlighted how visual field deficits and low margin reflex distance 1 (MRD1) measurements can affect down-gaze function. One small study (n=34) specifically demonstrated that ptosis repair can improve down-gaze impairment.
  The report concluded by offering guidelines to help determine when surgical intervention is likely to result in meaningful functional improvement. However, the authors emphasized that these recommendations are based on a limited number of low-quality studies with small sample sizes. Most of the included studies were classified as Level III evidence and primarily focused on the outcomes of surgical correction rather than on identifying functional impairment itself. As such, the evidence base—composed largely of case reports with methodological limitations—was deemed insufficient to establish definitive selection criteria for upper eyelid ptosis and blepharoplasty surgery.[2]

- In 2019, Hollander and colleagues conducted a comprehensive systematic review examining the functional outcomes of upper eyelid blepharoplasty.[3] Out of 3,525 studies initially identified, 28 met the inclusion criteria and were analyzed in the final review. The outcomes assessed included dry eye symptoms, upper visual field expansion, eyebrow height, corneal shape, upper eyelid skin sensitivity, contrast sensitivity, eyelid movement (kinematics), and overall quality of life. The authors concluded that upper eyelid blepharoplasty offers several functional benefits, notably improvements in visual field, reduction in headache symptoms, and enhanced quality of life. However, the review's findings were limited by the predominance of female participants in the included studies—some with 80–100% female samples—which may affect the generalizability of the results. Additionally, the lack of standardized surgical techniques across studies introduced variability that further limited the strength of the conclusions.

CLINICAL PRACTICE GUIDELINES

American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS)

The 2015 ASOPRS guidelines on "Functional Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair"[1] recommend the following:

"Recommended coverage indications

I. Upper eyelid blepharoplasty (CPT 15823) should be considered medically necessary when documentation demonstrates:

A. The patient's complaint of interference with daily visual tasks or visual field-related activities, and
B. Visual obstruction due to excessive overhanging skin resting on or depressing the lashes or eyelid margin. Visual obstruction is defined by peripheral visual field testing consistent with the recommended documentation requirement (see below).

II. Upper eyelid ptosis repair (CPT 67901, 67902, 67903, 67904, 67906, 67908) should be considered medically necessary when documentation demonstrates:
A. The patient's complaint of interference with vision or visual field-related activities, and
B. A margin to reflex distance (MRD) less than or equal to 2 mm in primary or downgaze.
C. Visual obstruction due to ptotic upper eyelid. Visual obstruction is defined by peripheral visual field testing consistent with the recommended documentation requirement (see below).
D. The position of one upper eyelid, which initially appears not to meet criteria but becomes more ptotic with an MRD of 2 mm or less when the other, more ptotic eyelid is elevated (i.e. Hering's Law).

III. Repair of brow ptosis (CPT 67900) should be considered medically necessary when documentation demonstrates:
E. Brow ptosis to the extent it contributes to skin fold overlap and/or blepharoptosis meeting the criteria outlined above for upper eyelid blepharoplasty and/or ptosis surgery.

<u>Recommended documentation requirements</u>

1. Clinical notes documenting patient complaints of visual impairment secondary to abnormal eyelid or brow position resulting in limitation of daily activities such as reading, driving, and difficulty seeing objects approaching from the periphery, or redundant upper eyelid skin resulting in looking through the eyelashes or seeing the upper eyelid skin.
2. Clinical notes documenting an MRD of 2 mm or less for blepharoptosis repair.
3. Peripheral visual field testing performed with the eyelid and brow in the resting position that documents a baseline superior visual field of 30 degrees or less from fixation and improvement of at least 12 degrees over baseline with eyelid and brow elevation. Both manual, including Goldmann and tangent screen, and automated fields are acceptable. The measurement of a patient's superior visual field is defined as the lowest point seen at the vertical meridian. Visual fields are not required for children or other patients physically unable to perform visual field testing.
4. Photographs documenting the above including at least a good quality frontal upper face photograph, with the gaze in primary position clearly showing the corneal light reflex unless the ptotic tissue is so severe as to obscure the light reflex thus demonstrating severe ptosis and/or dermatochalasis.
5. Oblique or lateral photographs if helpful in further demonstrating overhanging excess skin as well as lash ptosis due to mechanical displacement by the overhanging skin fold.
6. Frontal photograph with the patient looking in down-gaze documenting those cases in which the ptosis is worse in the down-gaze position.

7. Photograph with the brows elevated or taped up to a normal position to document the effect of brow ptosis when both eyelid ptosis repair and brow ptosis repair are planned."

American Academy of Ophthalmology (AAO)

The 2011 AAO position statement on "Functional Indications for Upper Eyelid Ptosis and Blepharoplasty Surgery"[2] stated the following:

"Ptosis and upper eyelid blepharoplasty surgery were found to be functionally beneficial for each of these quantitative findings:

- MRD_1 of ≤2 mm measured in primary gaze
- Superior visual field loss of 12 degrees or 24%
- Down-gaze ptosis impairing reading documented by MRD_1 of ≤2 mm[7] measured in down gaze

Ptosis and upper eyelid blepharoplasty were also found to be functionally beneficial for the following qualitative findings:

- Self-reported functional impairment from upper eyelid droop
- Chin-up backward head tilt induced by visual field impairment caused by lids
- Interference with occupational duties and safety resulting from visual impairment caused by the upper lids
- Symptoms of discomfort, eye strain, or visual interference due to the upper eyelid position

The reviewed literature did not provide strong data on the following functional indications for ptosis and blepharoplasty surgery:

- Dermatitis
- Difficulty wearing a prosthesis in an anophthalmic socket
- Temporal visual field impairment preventing a driver from meeting licensing standards

Ptosis and dermatochalasis can occur concomitantly. Each has its own functional indications for repair, and different surgical procedures are required to correct them."

The 2017 AAO Amblyopia Preferred Practice Pattern clinical practice guidelines on amblyopia, stated the following:[4]

- "All children with amblyopia should be offered treatment regardless of age.
- Surgery to treat the cause of amblyopia may be indicated when the cause of the amblyopia can be attributed to blepharoptosis that is severe enough to prevent successful amblyopia therapy without surgical correction."

EVIDENCE SUMMARY

The medical necessity of blepharoplasty, blepharoptosis and brow lift procedures for the various indications addressed in this policy are primarily based on clinical rationale and current evidence-based

clinical practice guidelines. When medical necessity criteria for these procedures are not met, these procedures are considered to be cosmetic in nature.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online here.

BILLING GUIDELINES AND CODING

When a Medically Necessary Procedure is Performed with a Cosmetic Procedure

When a cosmetic and noncovered surgical procedure is performed in the same operative session as a medically necessary and covered surgical procedure, medical necessity review will be conducted for the allowable procedure only. For example, if dermatochalasis would be resolved sufficiently by brow ptosis repair alone, an upper lid blepharoplasty in addition would be considered cosmetic. Similarly, if a visual field deficit would be resolved sufficiently by upper lid blepharoplasty alone (for tissue hanging over the lid margin), a blepharoptosis repair in addition would be considered cosmetic.

The following codes do not require prior authorization when billed with diagnosis codes *F64.0, F64.1, F64.8, or F64.9.* Prior authorization is required for other diagnoses. Please refer to the "Prior Authorization" code list for further information.

CODES*		
CPT	15820	Blepharoplasty, lower eyelid
	15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
	15822	Blepharoplasty, upper eyelid
	15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
	67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
	67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
	67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
	67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
	67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
	67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
	67909	Reduction of overcorrection of ptosis
	67911	Correction of lid retraction
	67914	Repair of ectropion; suture
	67915	Repair of ectropion; thermocauterization
	67916	Repair of ectropion; excision tarsal wedge
	67917	Repair of ectropion; extensive (eg, tarsal strip operations)
	67921	Repair of entropion; suture
	67922	Repair of entropion; thermocauterization
	67923	Repair of entropion; excision tarsal wedge
	67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
	67930	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; partial thickness
	67935	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). White Paper on Functional Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair. Approved: 01/15/2015.

https://www.asoprs.org/assets/docs/1%20-%20FINAL%20ASOPRS%20White%20Paper%20January%202015.pdf. Accessed 5/11/2025.
2. Cahill KV, Bradley EA, Meyer DR, et al. Functional indications for upper eyelid ptosis and blepharoplasty surgery: a report by the American Academy of Ophthalmology. *Ophthalmology.* 2011;118(12):2510-2517.https://www.ncbi.nlm.nih.gov/pubmed/22019388.
3. Hollander MHJ, Contini M, Pott JW, Vissink A, Schepers RH, Jansma J. Functional outcomes of upper eyelid blepharoplasty: A systematic review. *J Plast Reconstr Aesthet Surg.* 2019;72(2):294-309
4. American Academy of Ophthalmology. Amblyopia Preferred Practice Pattern. Pediatric Ophthalmology/Strabismus Panel. 2017. https://pubmed.ncbi.nlm.nih.gov/29108744/. Accessed 5/11/2025.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
7/2023	Annual update. No changes
7/2024	Annual update. No criteria changes. Title update
10/2025	Annual update. No changes to criteria.
11/2025	Interim update. Updated criteria.