MEDICAL POLICY	Eye: Blepharoplasty, Blepharoptosis Repair, and Brow Lift (Medicare Only)
Effective Date: 4/1/2021  4/1/2021 Medical Officer Date	Medical Policy Number: 225 Medical Policy Committee Approved Date: 12/18; 12/19; 3/2021

See Policy CPT CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Blepharoplasty, Eyelid Surgery, and Brow Lift	• Local Coverage Determination (LCD): Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286)[1]

BILLING GUIDELINES

Please see Local Coverage Article Billing and Coding: Blepharoplasty, Eyelid Surgery, and Brow Lift (A57191) for any relevant billing guidelines.

CPT CODES

Medicare Only	
Prior Authorization Required	
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)
Not Covered	
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
No Prior Authorization Required	
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

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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 Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

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.

REGULATORY STATUS

Mental Health Parity Statement

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.

MEDICAL POLICY CROSS REFERENCES

- Cosmetic and Reconstructive Surgery
- Gender Affirming Surgical Interventions

REFERENCES

1. Centers for Medicare & Medicaid Services. LCD L36286. LCD Title: Blepharoplasty, Eyelid Surgery, and Brow Lift. Effective 10/01/2018. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36286. Accessed 2/24/2021.
2. Centers for Medicare & Medicaid Services. MLN Matters Number: MM10236. October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS). Effective: 10/01/2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10236.pdf. Accessed 2/24/2021.
3. Centers for Medicare & Medicaid Services. MLN Matters Number: MM10259. October 2017 Update of the Ambulatory Surgical Center (ASC) Payment System. Effective: 10/01/2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10259.pdf. Accessed 10/11/2018.