



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

Subject **Blepharoplasty,
Reconstructive Eyelid Surgery,
and Brow Lift**

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Table of Contents

Coverage Policy	1
General Background	3
Coding/Billing Information	7
References	10
Policy History	13

Hyperlink to Related Coverage Policies

OnabotulinumtoxinA (Botox® A)
Tissue-Engineered Skin Substitutes and
Platelet-Derived Growth Factors

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2011 CIGNA

Coverage Policy

Coverage for blepharoplasty, blepharoptosis repair and brow lift is dependent upon benefit plan language, may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit and may be governed by state mandates.

Under many benefit plans, these procedures are not covered when performed solely for the purpose of improving or altering appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one's appearance. In addition, blepharoplasty is specifically excluded under many benefit plans.

Under many benefit plans formerly administered by Great-West Healthcare reconstructive services and surgery are covered when the reconstruction services are being performed for one of the following primary purposes: 1) to relieve severe physical pain caused by an abnormal body structure; or 2) to treat a functional impairment caused by an abnormal body structure or restore an individual's normal appearance, regardless of whether a functional impairment exists when the abnormality results from a documented illness that occurred within the preceding 12 months.

Please refer to the applicable benefit plan language to determine the terms and conditions of coverage.

If coverage for the specific service is available, the following conditions of coverage apply:

CIGNA covers an UPPER eyelid reconstructive blepharoplasty (Current Procedural Terminology [CPT] code 15822, 15823) as medically necessary for ANY of the following indications when the associated criteria are met:

- blepharochalasis, dermatochalasis or pseudoptosis with upper visual field loss of at least 30 degrees or 50% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelid **AND** preoperative frontal photographs demonstrate **BOTH** of the following:
 - light reflex in the cornea with the head perpendicular to the plane of the camera (i.e., not tilted)
 - findings consistent with visual field loss documented on visual field testing
- difficulty tolerating a prosthesis in an anophthalmic socket
- epiphora (i.e., excessive tearing) due to ectropion and/or punctal eversion
- painful blepharospasm that is refractory to medical management (e.g., botulinum toxin injections)
- orbital sequelae of thyroid disease or nerve palsy (e.g., exposure keratitis)
- upper-eyelid defect caused by trauma, tumor or ablative surgery resulting in a severe physical deformity or disfigurement which is causing functional visual impairment as confirmed by preoperative frontal photographs

CIGNA covers UPPER eyelid ptosis (blepharoptosis) repair (CPT code 67901—67908) as medically necessary when there is upper visual field loss of at least 30 degrees or 50% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelid AND preoperative frontal photographs demonstrate BOTH of the following:

- light reflex in the cornea with the head perpendicular to the plane of the camera (i.e., not tilted) **OR** encroachment of the upper eyelid into the visual field which would prevent the corneal light reflex
- findings consistent with visual field loss documented on visual field testing

CIGNA covers UPPER eyelid ptosis (blepharoptosis) repair (CPT code 67901—67908) as medically necessary in an infant or child less than or equal to seven years of age when there is a functional visual impairment as documented by preoperative frontal photographs which demonstrate light reflex in the cornea with the head perpendicular to the plane of the camera (i.e., not tilted) OR encroachment of the upper eyelid into the visual field which would prevent the corneal light reflex.

CIGNA covers LOWER or UPPER eyelid ectropion or entropion repair (CPT code 67914—67924) as medically necessary for corneal and/or conjunctival injury or disease due to ectropion, entropion or trichiasis.

CIGNA covers a brow lift (e.g., repair of brow ptosis for laxity of the forehead muscles) (CPT code 67900) when ALL of the following medical necessity criteria are met:

- brow ptosis is causing functional visual impairment confirmed by photographs demonstrating that the eyebrow is below the supraorbital rim
- individual complains of interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through eyelashes or seeing upper eyelid skin
- upper visual field loss of at least 30 degrees or 50% on visual field testing that cannot be corrected by upper lid blepharoplasty

CIGNA covers a combination of ANY of the above procedures as medically necessary when the medical necessity criteria for each procedure are met and BOTH of the following additional criteria are met:

- visual field testing demonstrates a visual impairment that cannot be addressed by one procedure alone
- lateral and full-face photographs with attempts at 1) brow elevation and, 2) upward gaze (i.e., with the brow relaxed) support the request

CIGNA covers surgical correction of UPPER or LOWER eyelid retraction (CPT code 67911) as medically necessary when there is functional impairment or failure of medical management of symptoms. Surgical

correction of UPPER or LOWER eyelid retraction that is being performed for the sole purpose of improving appearance is considered cosmetic in nature and not medically necessary.

CIGNA covers a lower eyelid reconstructive blepharoplasty (CPT code 15820, 15821) as medically necessary for ANY of the following indications when there is a functional visual impairment as documented by preoperative frontal photographs:

- lower eyelid edema due to a metabolic or inflammatory disorder when the edema is causing a persistent visual impairment (e.g., secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome) and is unresponsive to conservative medical management
- corneal and/or conjunctival injury or disease due to entropion or epiblepharon
- lid laxity with uncontrolled tearing and/or irritation as documented by history

CIGNA does not cover lower eyelid blepharoplasty in the absence of a functional impairment or is being performed for the sole purpose of improving appearance because it is considered cosmetic in nature and not medically necessary.

General Background

Blepharoplasty is defined as any operation for the restoration of a defect in the eyelid. Blepharoplasty includes procedures to repair ptosis, eyelid retraction, entropion, ectropion, trichiasis or defects following excision of tumors. A blepharoplasty may be performed for functional or cosmetic reasons. Cosmetic surgery is an attempt to improve the appearance of structures or tissues that are functionally and histologically normal. The goal of functional or reconstructive surgery is to restore to normal a structure that has been altered by infection, trauma, degeneration, inflammation, developmental errors, or neoplasia. Blepharoplasty is often done in combination with other functional or cosmetic procedures (e.g., brow lift) to restore more complete function or facial expression (American Society of Plastic Surgeons [ASPS], 2007a; ASPS, 2007b; American Academy of Ophthalmology [AAO], 2003).

Prior to blepharoplasty, reconstructive eyelid surgery and/or brow lift, a preoperative evaluation, which includes a detailed medical and ocular history along with a thorough ophthalmologic examination, is generally performed. It is recommended that patients be examined for active eye disease, dry eyes and thyroid disease, which are contraindications to eyelid surgery. Fine examination of the lid margin for chronic blepharitis, evidence of lid retraction or laxity, and signs of associated systemic disease such as thyroid disease or other problems should be assessed prior to surgery. The excessive eye bulk that may result from these conditions will typically resolve after adequate medical treatment, obviating the need for surgical intervention. The physical examination may include a Schirmer test, tear film break-up time, visual acuity with and without correction, and visual fields testing. It is recommended that preoperative photographs be taken with the eyes in primary position (Purewal, et al., 2005; Spinelli, 2004b; Brown, 2003; Stephenson, 1997).

Visual Field Testing

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, blepharoptosis repair and/or brow lift is the superior visual field. The normal extent of the superior visual field is approximately 55–60° at the 90° meridian. Impairment of the superior visual field can range from 20%, considered mild ptosis, to 64% 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. In a study by Riemann et al. (2000), Goldmann manual kinetic and Humphrey automated static visual field testing were both effective in documenting ptosis-associated visual field loss (AAO, 2003; Riemann, et al., 2000; Meyer, et al., 1993; Meyer, et al., 1989). Visual field testing is generally not performed in infants and children less than or equal to seven years of age.

Conditions Associated with Blepharoplasty, Reconstructive Eyelid Surgery and Brow Lift

Blepharochalasis: Blepharochalasis is a rare condition that afflicts young people, usually in their teens. Redundant skin of the upper eyelid hangs down and may conceal the tarsal margin when the eye is open,

impairing the visual field. It may be associated with the disease process of chronic blepharoeidema and can lead to thinning of the eyelid skin and prolapse of orbital fat. Blepharoplasty, usually in combination with advancement of the levator aponeurosis, may be indicated (Purewal, et al., 2005; AAO, 2003).

Blepharospasm: Blepharospasm is a condition in which the muscles in the eyelids and around the eyes twitch uncontrollably. There is no cure for this condition, and effective treatments are limited. Uncontrolled blepharospasm can become debilitating. Treatment can include artificial tear drops or lubricating ointment, or both. The treatment of choice for blepharospasm is an injection of botulinum toxin in the eyelids and around the eyes to paralyze them. This is a temporary treatment lasting about three to four months. If botulinum toxin is not effective, surgery can be considered. Blepharoplasty surgery involves removing the surrounding eye muscles (complete or partial myectomy) to control the blepharospasm permanently (Faucett, 2008; Patel, et al., 2005).

Brow Ptosis (Brow Lift): Brow ptosis refers to sagging tissue of the eyebrows and/or forehead. Brow ptosis may accentuate upper eyelid skin redundancy. As the brow descends below the supraorbital rim, it pushes additional skin over the upper eyelid, thereby aggravating the functional deficits in the peripheral visual fields. Upper eyelid blepharoplasty alone may worsen the degree of brow ptosis by fixing the brow in an inferior position. Therefore, it is recommended that repositioning of the brow should be considered before the blepharoplasty is performed. An adjunct procedure, such as a lateral brow lift, may need to be added to the planned reconstructive blepharoplasty. Brow ptosis repair for laxity of the forehead muscles causing functional visual impairment is indicated when photographs show the eyebrow below the supraorbital rim, and there is documentation that visual field impairment cannot be corrected by reconstructive upper lid blepharoplasty alone, as shown by taped and standardized methods of visual field testing. Photographs are taken from front, side, and oblique views. It is recommended that the patient's brow be relaxed when assessing the eyebrow position. Complications of eyebrow lifts are rare but may include: nerve damage, scarring, hematoma, or alopecia (Hoenig, 2005; Spinelli, 2004c; Dailey, et al., 2003).

Dermatochalasis: The upper and lower eyelid appearance and function are impacted by the natural aging process. Dermatochalasis refers to excessive or redundant skin, typically superior to the palpebral fissure, which is the result of the loss of elasticity typically due to the aging process. Sometimes these changes are so severe in the upper lid that it obtrudes on the vision by hanging down over the lid margin, pushing down on the lashes against the cornea. Dermatochalasis is the most common indication for blepharoplasty (Purewal, et al., 2005; AAO, 2003).

Ectropion: Ectropion is a turning out or sagging of the upper or lower eyelid. The condition mainly affects the lower eyelid. The sagging lower eyelid leaves the eye exposed and dry. As a result, excessive tearing is common. If the condition is not treated, crusting of the eyelid, mucous discharge and irritation of the eye may occur. A serious inflammation may result and damage the eye. Corneal dryness and irritation may lead to eye infections, corneal abrasions, or corneal ulcers (ASOPRS, 2011b).

Ectropion can be diagnosed with a routine eye exam. Special tests are usually not necessary. No completely satisfactory nonsurgical approaches exist in the management of symptomatic ectropion. When the condition is mild, the patient may experience only mild irritation from conjunctival exposure, usually associated with epiphora and perhaps a foreign body sensation from corneal drying. Artificial tears during the day and ointments at night usually improve the symptoms. Taping the lid into position, a frost suture, or a temporary tarsorrhaphy with sutures or glue may be useful. Nighttime eye shields which seal in moisture may be helpful. Some cases of ectropion caused by nerve problems can be treated temporarily if the eyelid nerves are expected to recover (ASOPRS, 2011b; Robinson, et al., 2008; Weizer, et al., 2006; Eliasoph, 2005; Tse, 2003).

Medical management may not be adequate when the lid malposition is so severe that corneal breakdown occurs. Surgical treatment depends on the underlying cause. There are six pathological elements that may be present in an ectropic eyelid including: horizontal lid laxity, medial canthal tendon laxity, punctal malposition, vertical tightness of the skin, orbicularis palsy secondary to seventh nerve palsy, and lower eyelid retractors disinsertion. One or more of these components may be present in an ectropic eyelid. Proper recognition of the underlying anatomic defect enables the surgeon to select the appropriate surgical procedure for correction. Scars can occur following trauma or the surgical removal of skin cancers. A skin graft taken from the upper eyelid, or from behind the ear can be used to repair the ectropion (ASOPRS, 2011b; Robinson, et al., 2008; ASOPRS, Tse, 2003).

Entropion: Entropion is an abnormal inward rotation of the eyelid. The relaxing of the eyelid tendons and eyelid muscles results in the eyelid turning inward. When the eyelid turns inward, the eyelashes and skin rub against the eye which can cause watering of the eyes (trichiasis), redness, irritation, or burning. Serious inflammation may lead to damage to the eye. Entropion occurs most commonly as a result of aging with the weakening of eyelid muscles. Entropion may occur after trauma and scar contraction or after surgery. The long-term use of medications such as some used for glaucoma may produce shrinkage and entropion. There are many subdivisions of entropion. The most common type is involitional entropion (ASOPRS, 2011c; Weizer, et al., 2006; Eliasoph, 2005; Gigantelli, 2004; Katowitz, et al., 2003).

Patients who have entropion are typically evaluated as possible surgical candidates. Medical therapy is typically attempted prior to surgical repair. The extent of ocular findings, patient's age, and systemic comorbidities must be considered in developing a treatment plan. A slit lamp is used to examine the surface of the eyeball for tear problems or for damage from inverted eyelashes. Surgery to repair entropion is usually performed on an outpatient basis in the physician's office or in an ambulatory surgical center under local anesthesia. There are a number of surgical procedures, and each surgeon has a preferred surgical method to correct entropion (ASOPRS, 2011c; Weizer, et al., 2006; Eliasoph, 2005; Gigantelli, 2004; Katowitz, et al., 2003).

Epiblepharon: In epiblepharon, a horizontal fold of redundant pretarsal skin and orbicularis muscle extends beyond the eyelid margin and compresses the eyelashes against the globe. Generally, the condition is bilateral, prevalent in Asian populations, and commonly involves the lower lid. Some patients demonstrate the clinical findings at all times, whereas others are symptomatic only in downgaze. Although both epiblepharon and congenital entropion result from lower eyelid retractor defects, their clinical presentation and course contrast sharply with nearly 80% of children who show epiblepharon have no ocular complaints. Frequently, the condition resolves with the normal vertical growth of the facial bones. Although the majority of patients can be managed conservatively, treatment should not be delayed in symptomatic cases. A transcutaneous reattachment of the lower lid retractor anterior fibers to the skin and orbicularis is achieved by reforming the lower eyelid crease through the removal of a horizontal skin and orbicularis muscle strip and deep fixational suture closure (Gigantelli, 2008).

Ptosis (Blepharoptosis): Ptosis is an abnormally low position of the upper eyelid margin which is determined while the eye is looking in primary gaze. Ptosis may result from masses, trauma, and congenital or acquired deformities of the levator or Müller neuromuscular complexes. The causes of ptosis may be classified as mechanical, neurogenic, myogenic, and neuromuscular junctional. Ptosis may be categorized by age of onset (congenital versus acquired), severity, and physiological etiology. Patients with ptosis may present with various symptoms, including visual field obstruction, headache, and fatigue. Surgery is considered in patients who are symptomatic. The goal of ptosis repair is to elevate the eyelid without causing excessive lagophthalmos or ocular exposure (Custer, 2008; Lee, et al., 2003).

Conditions that can mimic true ptosis but that are mechanical (pseudoptosis), and not an isolated intrinsic condition include: anophthalmic socket, hypertropia (elevation of the eyeball), blepharospasm or increased facial tone, enophthalmos (the affected eyeball is retrodisplaced with the upper eyelid draping over the anterior corneal surface), and severe dermatochalasis with or without associated brow ptosis (Spinelli, 2004c; Lee, et al., 2003).

The eyelid fissure is a measurement of the opening of the eyelid when the eye is in primary position looking straight ahead. It is measured in millimeters at the center of the eyelid from the bottom of the upper lid to the top of the lower lid. The normal measurement is 9–10 mm. Ptotic eyes are defined as those with eyelid fissures less than 9 mm. Margin reflex distances (MRDs) are measurements that are used. MRD_1 is the distance from the upper eyelid to the corneal light reflex. Measurements < 4 mm are considered abnormal. MRD_2 is the distance from the corneal light reflex to the lower lid. A measurement of > 5 mm represents a lower eyelid that is too low and can be caused by entropion or ectropion. A patient can have a ptotic upper eyelid and a normal eyelid fissure if the lower eyelid position is abnormally low. Levator function is a measurement of how well the levator muscle works. Normal function is greater than 11 mm. A poor levator function is ≤ 4 mm (Custer, 2008; Edmonson, et al., 2005).

It is recommended that before ptosis surgery is considered, photographic documentation of the patient while looking in primary gaze, down-gaze, and side views be required. Visual fields may be performed on each ptotic eyelid with the eyelids in their natural position and again with the eyelids taped up to simulate postsurgical

response. It is recommended that the patient be examined for pupil abnormalities and motility problems prior to surgery. The Schirmer test and slit lamp examination are performed to rule out dry eye (Custer, 2008; Edmonson, et al., 2005; Spinelli, 2004c).

The most common complications of ptosis surgery are a part of the inherent inaccuracy of the procedure which involves undercorrections and overcorrections. Depending on the case series, the rate of undercorrections and overcorrections varies from 5–35%. Massaging the eyelid downward may resolve or reduce overcorrection. It is recommended that reoperating on patients with overcorrections be completed within two weeks of the original surgery, after edema has resolved, and before scarring has taken place. True complications of ptosis surgery can include lagophthalmos, exposure keratitis, lid lag, corneal ulceration, and visual loss. Patients who have congenital ptosis, postoperative lagophthalmos, or acquired myopathies require continued evaluation after surgery to monitor for possible ocular exposure, or the development of associated ophthalmic conditions (Custer, 2008; Edmonson, et al., 2005).

Thyroid Disease: Symptoms that are associated with thyroid disease may include unilateral or bilateral upper-eyelid retraction and proptosis (i.e., protruding eye). Most often, medical treatment for the thyroid pathology will resolve these deformities, but occasionally, reconstructive blepharoplasty may be necessary to prevent corneal exposure and erosion (AAO, 2003).

Professional Societies/Organizations

American Society of Plastic Surgeons (ASPS): The ASPS practice parameter for blepharoplasty and the ASPS recommended insurance coverage criteria for third-party payors-blepharoplasty states that when there is visual field impairment blepharoplasty procedures are considered to be reconstructive. Blepharoplasty is considered reconstructive by the ASPS when it is performed to correct visual impairment caused by ptosis, blepharochalasis; repair congenital abnormalities or defects caused by trauma or tumor-ablative surgery. If the patient is experiencing visual field impairment, formal visual field testing by an Optometrist or Ophthalmologist is recommended. Photographs are usually taken to document the preoperative condition and aid the surgeon in planning surgery. Additional photographs may include upward and downward gaze as well as oblique views. It may be necessary for patients with a history of dry eye to undergo a Schirmer's test. Ptosis of the upper eyelid is determined by measuring the palpebral fissure width and margin reflex distance. Levator excursion is also assessed. The forehead and eyebrow should be evaluated for brow ptosis. The ASPS states that when blepharoplasty is performed to improve a patient's appearance, in the absence of any signs and/or symptoms of functional abnormalities, the procedure is considered cosmetic (ASPS, 2007a; ASPS, 2007b). There have been no updates to the practice parameter or recommended insurance coverage criteria since 2007.

American Academy of Ophthalmology (AAO): The current AAO ophthalmic procedures assessment on the functional indications for upper and lower blepharoplasty states the most common functional indication for blepharoplasty is a superior visual field defect secondary to redundant upper eyelid tissue (dermatochalasis) that overhangs the eyelid margin. Because dermatochalasis and true ptosis often co-exist, blepharoplasty at the time of ptosis repair is often indicated. Brow ptosis may coexist with dermatochalasis, therefore requiring brow lift and blepharoplasty in some patients. The authors state that studies confirm that visual field loss from malpositioned upper eyelids ranges from 20% for mild ptosis, to 64% in advanced cases where the eyelid crosses the middle of the pupil (AAO, 2003). There have been no updates to this assessment since 2003.

There are at least two situations in which a functional lower eyelid blepharoplasty is indicated in (AAO, 2003):

- in patients with massive lower eyelid edema that may be secondary to systemic corticosteroid therapy, myxedema, Graves' disease, nephrotic syndrome, or a number of metabolic or inflammatory disorders
- epiblepharon or entropion in which an extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea

The following underlying conditions may warrant functional blepharoplasty (AAO, 2003):

- mechanical: dermatochalasis causing "pseudoptosis" with superior visual field defect, blepharoconjunctivitis, or associated true blepharoptosis
- inflammatory: Graves' ophthalmopathy and other metabolic disorders, blepharochalasis, floppy eyelid syndrome

- traumatic: orbital fracture or following skin grafting for eyelid tissue or reconstruction

Summary

Based on position statements by professional societies and evidence in the peer-reviewed scientific literature, there are specific clinical indications for blepharoplasty, reconstructive eyelid surgery, and brow lift. Blepharoplasty, blepharoptosis repair and brow lift performed to improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities are considered cosmetic and not medically necessary.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary only when coverage is available for the specific service. Benefit exclusions and limitations may apply. Upper and lower blepharoplasties are specifically excluded under many plans and therefore may not be covered:

Lower Eyelid Reconstructive Blepharoplasty

Covered when medically necessary:

CPT [®] * Codes	Description
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad

ICD-9-CM Diagnosis Codes	Description
242.10-242.00	Toxic uninodular goiter
360.30	Unspecified hypotony of eye
370.34	Exposure keratoconjunctivitis
374.00	Entropion, unspecified
374.01	Senile entropion
374.02	Mechanical entropion
374.03	Spastic entropion
374.04	Cicatricial entropion
374.05	Trichiasis without entropion
374.82	Edema of eyelid

Cosmetic in Nature/Not Medically Necessary/Not Covered:

ICD-9-CM Diagnosis Codes	Description
V50.1	Other plastic surgery for unacceptable cosmetic appearance

Upper Eyelid Reconstructive Blepharoplasty

Covered when medically necessary:

CPT [®] * Codes	Description
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid

ICD-9-CM Diagnosis Codes	Description
242.10-242.00	Toxic uninodular goiter
333.81	Blepharospasm
374.00	Unspecified entropion
374.01	Senile entropion
374.02	Mechanical entropion
374.03	Spastic entropion
374.04	Cicatricial entropion
374.05	Trichiasis without entropion
374.30	Unspecified ptosis of eyelid
374.32	Myogenic ptosis
374.33	Mechanical ptosis
374.87	Dermatochalasis
743.00	Clinical anophthalmos, unspecified
996.69	Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft
V45.78	Acquired absence of organ, eye

Cosmetic in Nature/Not Medically Necessary/Not Covered:

ICD-9-CM Diagnosis Codes	Description
V50.1	Other plastic surgery for unacceptable cosmetic appearance

Brow Lift

Covered when medically necessary:

CPT®* Codes	Description
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

ICD-9-CM Diagnosis Codes	Description
368.44	Other localized visual field defect
374.30	Unspecified ptosis of eyelid
374.31	Paralytic ptosis
374.32	Myogenic ptosis
374.33	Mechanical ptosis
374.34	Blepharochalasis

Cosmetic in Nature/Not Medically Necessary/Not Covered:

ICD-9-CM Diagnosis Codes	Description
V50.1	Other plastic surgery for unacceptable cosmetic appearance

Upper Eyelid Ptosis

Covered when medically necessary:

CPT^{®*} Codes	Description
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)

ICD-9-CM Diagnosis Codes	Description
368.44	Other localized visual field defect
374.30	Unspecified ptosis of eyelid
374.31	Paralytic ptosis
374.32	Myogenic ptosis
374.33	Mechanical ptosis
374.34	Blepharochalasis

Cosmetic in Nature/Not Medically Necessary/Not Covered:

ICD-9-CM Diagnosis Codes	Description
V50.1	Other plastic surgery for unacceptable cosmetic appearance

UPPER or LOWER Eyelid Retraction

Covered when medically necessary:

CPT^{®*} Codes	Description
67911	Correction of lid retraction

ICD-9-CM Diagnosis Codes	Description
333.81	Blepharospasm
351.0	Bell's palsy
370.34	Exposure keratoconjunctivitis
374.04	Cicatricial entropion
374.20	Unspecifice lagophthalmos
374.21	Paralytic lagophthalmos
374.22	Mechanical lagophthalmos
374.23	Cicatricial lagophthalmos
374.41	Eyelid retraction or lag
376.21	Thyrotoxic exophthalmos
743.62	Congenital deformity of eyelid

Cosmetic in Nature/Not Medically Necessary/Not Covered:

ICD-9-CM Diagnosis Codes	Description
V50.1	Other plastic surgery for unacceptable cosmetic appearance

LOWER or UPPER Eyelid Ectropion or Entropion Repair

Covered when medically necessary:

CPT ^{®*} Codes	Description
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 capsulopalpral fascia repairs operation)

ICD-9-CM Diagnosis Codes	Description
370.34	Exposure keratoconjunctivitis
374.00	Entropion, unspecified
374.01	Senile entropion
374.02	Mechanical entropion
374.03	Spastic entropion
374.04	Cicatricial entropion
374.05	Trichiasis without entropion
374.10	Ectropion, unspecified
374.11	Senile ectropion
374.12	Mechanical ectropion
374.13	Spastic ectropion
374.14	Cicatricial ectropion
374.34	Blepharochalasis

Cosmetic in Nature/Not Medically Necessary/Not Covered:

ICD-9-CM Diagnosis Codes	Description
V50.1	Other plastic surgery for unacceptable cosmetic appearance

***Current Procedural Terminology (CPT[®]) © 2010 American Medical Association: Chicago, IL.**

References

1. American Academy of Ophthalmology (AAO). Functional indications for upper and lower eyelid blepharoplasty. Ophthalmology. 1995 Apr;102(4):693-5.

2. American Academy of Ophthalmology (AAO). Functional indications for upper and lower eyelid blepharoplasty. 1995. Maintained 2003. Accessed February 15, 2011. Available at URL address: <http://one.aao.org/CE/PracticeGuidelines/Ophthalmic.aspx?p=3>
3. American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). Patient information. Blepharoplasty. 2011a. Accessed February 15, 2011. Available at URL address: <http://www.asoprs.org>
4. American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). Patient information. Ectropion. 2011b. Accessed February 15, 2011. Available at URL address: <http://www.asoprs.org>
5. American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). Patient information. Entropion 2011c. Accessed February 15, 2011. Available at URL address: <http://www.asoprs.org>
6. American Society of Plastic Surgeons (ASPS). Practice Parameter for Blepharoplasty. March 2007a. Accessed February 15, 2011. Available at URL address: http://www.plasticsurgery.org/Medical_Professionals/Health_Policy_and_Advocacy/Health_Policy_Resources/Evidence-based_GuidelinesPractice_Parameters.html
7. American Society of Plastic Surgeons (ASPS). ASPS recommended insurance coverage criteria for third-party payors. Blepharoplasty. March 2007b. Accessed February 15, 2011. Available at URL address: http://www.plasticsurgery.org/Medical_Professionals/Health_Policy_and_Advocacy/Health_Policy_Resources/Recommended_Insurance_Coverage_Criteria.html
8. Anderson DR. Standard perimetry. *Ophthalmol Clin North Am*. 2003 Jun;16(2):205-12, vi.
9. Bashour M. Blepharoplasty, Ptosis Surgery. Last updated June 18, 2009. Accessed February 15, 2011. Available at URL address: <http://www.emedicine.com/ent/topic97.htm>
10. Brown BZ. Blepharoplasty. In: Levine MR, editor. *Manual of Oculoplastic Surgery*. 3rd ed. Philadelphia, PA: Butterworth Heinemann; 2003: Ch 9.
11. Caputy G. Brow Lift, Periorbital Rejuvenation. Last updated June 18, 2009. Accessed February 15, 2011. Available at URL address: <http://www.emedicine.com/plastic/topic428.htm>
12. CIGNA Government Services. Blepharoplasty/Blepharoptosis Repair. Medicare Part B carrier-North Carolina local medical review policy. L5703. Revision effective 12/31/2005. Last reviewed August 24, 2010. Accessed February 15, 2011. Available at URL address: http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=5703&lcd_version=15&basket=lcd%3A5703%3A15%3ABLEpharoplasty%2F+Blepharoptosis+Repair%3ACarrier%3ACIGNA+Government+Services+%2805535%29%3A
13. Cohen AJ, Mercandetti M. Ptosis, Adult. Updated November 18, 2009. Accessed February 15, 2011. Available at URL address: <http://www.emedicine.com/oph/topic201.htm>
14. Custer PL. Blepharoptosis. In: Yanoff M, Duker JS, editors. *Ophthalmology*. 3rd ed. St Louis, MO: Mosby; 2008: Ch 12.5.
15. Dailey RA, Saulny SM. Current treatments for brow ptosis. *Curr Opin Ophthalmol*. 2003 Oct;14(5):260-6.
16. Davis, MR. Brow Lift, Coronoplasty. Last updated November 10, 2009. Accessed February 15, 2011. Available at URL address: <http://www.emedicine.com/plastic/topic37.htm>
17. Edmonson BC, Wulc AE. Ptosis evaluation and management. *Otolaryngol Clin North Am*. 2005 Oct;38(5):921-46.

18. Eliasoph I. Current techniques of entropion and ectropion correction. *Otolaryngol Clin North Am.* 2005 Oct;38(5):903-19.
19. Faucett DC. Essential blepharospasm. In: Yanoff M, Duker JS, editors. *Ophthalmology*. 3rd ed. St Louis, MO: Mosby; 2008: Ch 12.8.
20. Federici TJ, Meyer DR, Lininger LL. Correlation of the Vision-related Functional Impairment Associated with Blepharoptosis and the Impact of Blepharoptosis Surgery. *Ophthalmology* 1999 Sep; 106(9):1705-12.
21. Friedman O, Zaldvar R, Wang T. Blepharoplasty. In: Flint, P, Haughey B, Lund V, editors. *Flint: Cummings Otolaryngology: Head & Neck Surgery*. 5th ed. St Louis, MO: Mosby; 2010: Ch 30.
22. Fung S, Malhotra R, Selva D. Thyroid orbitopathy. *Aust Fam Physician*. 2003 Aug;32(8):615-20.
23. Gigantelli JW. Entropion. In: Yanoff M, Duker JS, editors. *Ophthalmology*. 3rd ed. St Louis, MO: Mosby; 2008; Ch 12.6.
24. Hoenig JA. Comprehensive management of eyebrow and forehead ptosis. *Otolaryngol Clin North Am.* 2005 Oct;38(5):947-84.
25. Katowitz JA, Heher KL, Hollsten DA. Involutional Entropion. In: Levine MR. *Manual of Oculoplastic Surgery*. 3rd ed. Philadelphia, PA: Butterworth Heinemann; 2003: Ch 18.
26. Lee AG, Brazis PW. Ptosis. In: Lee, AG, editor. *Clinical pathways in neuro-ophthalmology: an evidence-based approach*. 2nd ed. New York, NY: Thieme; 2003: Ch 18.
27. Meyer DR, Stern JH, Jarvis JM, Lininger LL. Evaluating the Visual Field Effects of Blepharoptosis Using Automated Static Perimetry. *Ophthalmology* 1993 May;100(5):651-9.
28. Meyer DR, Linber JV, Powell SR, Odom JV. Quantitating the Superior Field Loss Associated with Ptosis. *Arch Ophthalmol* 1989 Jun;107(6):840-3.
29. Patel BC. Surgical management of essential blepharospasm. *Otolaryngol Clin North Am.* 2005 Oct;38(5):1075-98.
30. Patel MP, Shapiro MD, Spinelli HM. Combined hard palate spacer graft, midface suspension, and lateral canthoplasty for lower eyelid retraction: a tripartite approach. *Plast Reconstr Surg.* 2005 Jun;115(7):2105-14; discussion 2115-7.
31. Purewal BK and Bosniak S. Theories of upper eyelid blepharoplasty. *Theories of upper eyelid blepharoplasty*. *Ophthalmol Clin North Am.* 2005 Jun;18(2):271-8.
32. Riemann CD, Hanson S, Foster JA. A comparison of manual kinetic and automated static perimetry in obtaining ptosis fields. *Arch Ophthalmol.* 2000 Jan;118(1):65-9.
33. Rizk SS, Matarasso A. Lower eyelid blepharoplasty: analysis of indications and the treatment of 100 patients. *Plast Reconstr Surg.* 2003 Mar;111(3):1299-306; discussion 1307-8.
34. Robinson FO, Collin JR. Ectropion. In: Yanoff M, Duker JS, editors. *Ophthalmology*. 3rd ed. St Louis, MO: Mosby; 2008: Ch 12.7.
35. Shields M, Putterman A. Blepharoptosis correction. *Otolaryngol Head Neck Surg.* 2003 Aug;11(4):261-6.
36. Spinelli HM. Evaluation of the patient. In: Spinelli HM, editor. *Atlas of aesthetic eyelid and periorcular surgery*. 1st ed. Philadelphia, PA: Saunders; 2004a. Ch 2.

37. Spinelli HM. Upper lid blepharoplasty. In: Spinelli HM, editor. Atlas of aesthetic eyelid and periocular surgery. 1st ed. Philadelphia, PA: Saunders; 2004b. Ch 4.
38. Spinelli HM. Ptosis and upper eyelid retraction. In: Spinelli HM, editor. Atlas of aesthetic eyelid and periocular surgery. 1st ed. Philadelphia, PA: Saunders; 2004c. Ch 8.
39. Stephenson CB. Upper-eyelid blepharoplasty. Int Ophthalmol Clin. 1997 Summer; 37(3):123-32.
40. Tarrus-Montaner S, Lucarelli MJ, Lemke BN, Dortzbach RK. The surgical treatment of Graves' orbitopathy: a decade of progress. Ophthalmol Clin North Am. 2000 Dec;13(4):693-704.
41. Torre J, Vasconez LO. Blepharoplasty, Upper Lid Ptosis Surgery. Last updated September 1, 2010. Accessed February 15, 2011. Available at URL address: <http://emedicine.medscape.com/article/1281861-overview>
42. Trussler AP, Rohrich RJ. MOC-PSSM CME article: Blepharoplasty. Plast Reconstr Surg. 2008 Jan;121(1 Suppl):1-10.
43. Tse DT. Involitional ectropion repair. In: Levine MR, editor. Manual of Oculoplastic Surgery. 3rd ed. Philadelphia, PA: Butterworth Heinemann; 2003: Ch 21.
44. Wiezer JS, Michon JJ. Ectropion and entropion: Everted and inverted eyelids In: Fekrat S and Weizer JS, editors. All about your eyes. Durham, NC: Duke University Press; 2006. Ch 5. 45-7.

Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	4/15/2008	0045	Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift
Great-West Healthcare	10/26/2006	95.242.06	Blepharoplasty and Brow Ptosis Repair

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