

<b>BSC7.01</b>		<b>Blepharoplasty, Blepharoptosis Repair (Levator Resection) and Brow Lift (Repair of Brow Ptosis)</b>	
<b>Original Policy Date:</b>	January 1, 2002	<b>Effective Date:</b>	March 1, 2024
<b>Section:</b>	7.0 Surgery	<b>Page:</b>	Page 1 of 15

## Policy Statement

In interpreting whether a proposed procedure meets the definition of reconstructive surgery, as defined by law, the procedure may be denied as **not medically necessary** under **any** of the following conditions:

- I. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery
- II. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see [Policy Guidelines](#) and [Documentation for Clinical Review](#) sections)
- III. There is alternative approved medical or surgical intervention with equal or superior clinical outcomes
- IV. The procedure is for [cosmetic](#) purposes only

### Upper Eyelid Blepharoplasty

- I. Unilateral or bilateral (see Policy Guidelines) upper eyelid blepharoplasty may be considered **medically necessary** for an individual with **ALL** of the following:
  - A. The issue involves one or both eyes
  - B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function
  - C. The office notes demonstrate functional visual impairment with **both** of the following:
    1. Visual field perimetry testing demonstrating **both** of the following:
      - a. Superior visual field impairment within 30 degrees (untaped)
      - b. After lid taping, correction of the defect and restoration of the normal central vision field
    2. Preoperative quality photographic evidence clearly showing the problem (e.g., frontal, down gaze, oblique or side views as needed) including **both** of the following:
      - a. Before lid taping with the camera at eye level and patient in the straight gaze position
      - b. Demonstration of the true lid margin or the pseudo-lid margin
- II. Unilateral or bilateral upper eyelid blepharoplasty for a patient with an eyelid pathology that impacts visual function (other than field of vision) in at least one eye, may be considered **medically necessary** to treat **any** of the following:
  - A. Intractable pain caused by blepharospasm
  - B. To preserve corneal function (due to severe ectropion, entropion, or corneal exposure)
  - C. To correct congenital disease affecting visual development
  - D. To compensate for overall functional effects caused by trauma or as a result of tumor removal
  - E. To treat severe peri-orbital dysfunction caused by nerve paralysis or thyroid disorders
- III. Unilateral or bilateral upper eyelid blepharoplasty may be considered **medically necessary** for an individual with **ALL** of the following:
  - A. The issue involves one or both eyes

- B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function
- C. Ophthalmic prosthesis appearance is affected by excess eyelid skin

#### Lower Eyelid Blepharoplasty

- IV. Unilateral or bilateral lower eyelid blepharoplasty may be considered **medically necessary** to treat an individual with **ALL** the following:
  - A. The issue involves one or both eyes
  - B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function
  - C. The office notes provide preoperative quality photographs clearly showing the problem (e.g., frontal, down gaze, oblique or lateral views as needed) with **either** of the following:
    - 1. Massive lower eyelid edema causing functional visual impairment secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome, or other metabolic or inflammatory disorders
    - 2. Epiblepharon or entropion in which an extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea

#### Upper Eyelid Blepharoptosis/Ptosis Repair (Levator Resection)

- V. Unilateral or bilateral upper eyelid blepharoptosis/ptosis repair may be considered **medically necessary** for an individual with **ALL** of the following:
  - A. The issue involves one or both eyes
  - B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function
  - C. The office notes document that at least one eye meets **both** of the following:
    - 1. Visual field perimetry testing demonstrating **both** of the following:
      - a. Superior visual field impairment within 30 degrees (untaped)
      - b. After lid taping, correction of the defect and restoration of the normal central vision field
    - 2. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem including **both** of the following:
      - a. Before lid taping with the camera at eye level and patient in the straight gaze position
      - b. Demonstration of abnormal upper eyelid position, including ptosis encroaching upon the pupillary border

#### Unilateral or Bilateral Blepharoptosis/Ptosis Repair (Levator Resection)

- VI. Unilateral or bilateral blepharoptosis/ptosis repair (levator resection) may be considered **medically necessary** for infants or children younger than 18 years of age meeting **any** following criteria:
  - A. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem with **either**:
    - 1. An appearance that is outside the range of normal seen in large populations
    - 2. An impairment or condition in an individual less than nine years of age who in the judgment of the treating physician is at risk for occlusion amblyopia
  - B. The appearance is not clearly outside the range of normal, but a significant functional abnormality (related to ptosis) is documented by either visual field testing or other findings on exam (confrontation fields, head positioning, etc.)

### Brow Lift

- VII. Unilateral or bilateral brow lift/brow ptosis repair may be considered **medically necessary** for an individual with **ALL** of the following:
- A. The issue involves one or both eyes
  - B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function
  - C. The office notes document **both** of the following:
    1. Visual field perimetry testing demonstrating **both** of the following:
      - a. Superior visual field impairment within 30 degrees (untaped)
      - b. After lid taping, correction of the defect and restoration of the normal central vision field
    2. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem including **both** of the following:
      - a. Before lid taping with the camera at eye level and patient in the straight gaze position
      - b. Demonstration of the eyebrow below the supraorbital rim

**NOTE:** Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

### Policy Guidelines

If the Reconstructive Surgery Act definition is **not** met, procedure is generally considered to create **only marginal improvements in appearance** and is thus considered **not medically necessary**. Medical review may be requested.

Surgery will be allowed for both eyes when needed for symmetry or other reasons even if only one eye meets criteria for medical necessity.

For the purpose of this policy, the qualified reviewer will differentiate a normal structure from an abnormal one based on **any** of the following elements:

- The availability of published normative data for specific anatomic measurements (e.g., cephalometric data for orthognathic surgery)
- The normal structures wide range of accepted variations in diverse populations (e.g., nasal size and shape)
- The presence of a cosmetic implant, in the absence of adjacent native tissue structural pathology, does not constitute an abnormal structure (e.g., cosmetic unilateral, bilateral or asymmetrical saline breast implants)

In determining whether or not a procedure is likely to result in more than minimal improvement in appearance, the qualified reviewer will consider both the size and location of the structural abnormality.

“Cosmetic surgery” means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

### Description

Blepharoplasty is a surgical procedure intended to reconstruct upper or lower eyelid deformities by excising and/or repositioning redundant skin, muscle, or fat and reinforcing surrounding muscles and tendons. Blepharoptosis repair or levator resection is performed for ptosis, an abnormal eyelid droop, caused by dysfunction of the eyelid muscles. A brow ptosis repair or brow lift is performed when there is abnormal sagging of the eyebrows and/or forehead.

This policy addresses the functional indications for blepharoplasty, blepharoptosis repair, and brow lift. The most common functional indication is a superior field vision defect secondary to redundant upper eyelid tissue (dermatochalasis) that overhangs the eyelid margin or blepharoptosis encroaching upon the pupillary border. In some cases, a combination of blepharoplasty and/or blepharoptosis repair or brow lift may be required depending on the cause of the visual field deficit.

## Related Policies

- Reconstructive Services

## Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

## Regulatory Status

### State:

The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do **either** of the following (see also Blue Shield of California Medical Policy: Reconstructive Services):

- I. Create a normal appearance to the extent possible
- II. Improve function

## Rationale

Blepharoplasty and repair of blepharoptosis (upper eyelid drooping) are commonly accepted surgical procedures for the management of upper eyelid conditions. There is adequate evidence in the peer-reviewed medical literature to support the use of upper eyelid surgery in the event of significantly impaired superior field of vision associated with functional impairment. These procedures improve the patient's field of vision, quality of life, and activities of daily living (e.g., reading and driving).

Blepharoplasty is most commonly done for cosmetic reasons. Cosmetic surgery is performed to alter or reshape normal structures of the body in order to improve appearance. Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to either create a normal appearance to the extent possible or improve function. The following addresses functional indications for blepharoplasty, blepharoptosis repair, and brow lift.

A preoperative evaluation, which includes a detailed medical and ocular history along with an ophthalmologic examination, should be performed prior to functional blepharoplasty, blepharoptosis

repair or brow lift. It is recommended patients be examined for active eye disease, dry eyes, thyroid or systemic disease, which may be contraindications to eyelid surgery or for conditions that will typically resolve after adequate medical treatment. Physical exam typically includes a Schirmer test, tear film break-up time, visual acuity with and without correction, and visual fields testing.<sup>2</sup> However, visual testing is generally not performed in infants and children less than or equal to seven years of age.

Standard methods for demonstrating the degree of functional impairment or visual field loss include visual field perimetry assessments and measurement of the margin reflex distance -1 (MRD1), defined as the mid-pupil to upper eyelid distance.<sup>3</sup> The normal span of the superior vision field is approximately 55 to 60 degrees at the 90 degree meridian. Superior visual field impairment measured by visual field perimetry testing can range from 20% (mild ptosis) to 64% in the most severe cases where the eyelid crosses the middle of the pupil. In most cases, mild to moderate impairment of the superior visual field is not clinically significant and intervention is not required. However, severe or significant obstruction of the superior visual field causing difficulty with activities of daily living may require surgery. Calculation of the MRD1 involves measuring the distance between the corneal light reflex (central visual axis) and the edge of either the upper eyelid or upper eyelid skin, whichever is closest. Visual impairment is considered significant when there is an MRD1 measurement of 2.0 millimeters (mm).<sup>4,5</sup>

### Upper Eyelid Blepharoplasty

The most common functional indication for blepharoplasty is a superior visual field defect secondary to redundant upper eyelid tissue that overhangs the eyelid margin. Conditions associated with blepharoplasty include dermatochalasis, blepharochalasis, and pseudoptosis. Dermatochalasis is an aging change of the eyelids related to loss of tone in the elastic fibers of the skin. It is commonly seen in the older population and occasionally in younger adults. The eyelid changes reflect the effects of gravity, loss of elastic tissue, and weakening of the connective tissues. Blepharochalasis is a rare disorder that typically affects the upper eyelids characterized by intermittent eyelid edema. In approximately 50% of individuals, the condition is unilateral, and over time may result in relaxation of the skin of the eyelid due to atrophy of the intercellular tissue. Pseudoptosis or "false ptosis" exists when the eyelid has an appropriate position with respect to the eyeball and visual axis; however, the amount of excessive skin is so great and lax that it overhangs the eyelid margin and creates its own ptosis (also known as "hooding"). Conditions associated with pseudoptosis include anophthalmic socket, hypertropia (eyelid elevation), blepharospasm or increased facial tone, enophthalmos (recession of the eyeball within the orbit), and severe dermatochalasis with or without associated brow ptosis.<sup>6</sup>

Preoperative frontal photographs should be taken with the eyes in the primary gaze position demonstrating a light reflex in the cornea with the head perpendicular to the plane of the camera (i.e., not tilted).<sup>6-9</sup> A superior visual field loss of at least 30 degrees on visual field testing that is corrected when the upper lid margin is elevated by taping is required for blepharoplasty. Functional blepharoplasty usually involves excision of the skin and orbicularis muscle.

### Lower Eyelid Blepharoplasty

In general, lower lid blepharoplasty is considered a cosmetic procedure. However, the American Academy of Ophthalmology (AAO, 2003)<sup>10</sup> advised there were at least two situations in which a functional lower eyelid blepharoplasty was indicated:

- Middle-aged or elderly patients with massive lower eyelid edema that may be secondary to systemic corticosteroid therapy, myxedema, Graves' disease, nephritic syndrome, or a number of other metabolic or inflammatory disorders
- Cases of epiblepharon (inturning of the lashes) or entropion (inward folding of the eyelid) in which an extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea

### **Blepharoptosis Repair**

Blepharoptosis or ptosis refers to the drooping of the upper eyelid margin below its normal position secondary to muscle weakness or nerve dysfunction. The levator muscle is the major muscle responsible for elevating the upper eyelid. Common patient symptoms include difficulty seeing and prefrontal headaches due to chronic use of the frontalis muscle in an attempt to lift the eyelids.<sup>11</sup> Drooping of the upper eyelid can be assessed by comparing the current appearance to previous photographs while the eye is looking in primary gaze (looking straight ahead). The normal position of the upper eyelid is greater than 2.5 mm above the midpupil.

Ptotic eyes are defined as those with eyelid fissures (a measurement of the opening of the eyelid when the eye is in primary gaze) less than 9 mm; normal measurement is 9 to 10 mm. Measurement of the MRD1 of less than 4 mm is considered abnormal. Measurement of the MRD2 (distance from the corneal light reflex to the lower lid) of less than 5 mm is considered abnormal and may be caused by an entropion or ectropion. Levator function is measured by how well the levator muscle works. A measurement of greater than 11 mm is considered normal function and a measurement of less than or equal to 4 mm is considered poor levator function.<sup>11</sup>

Ptosis can occur for a variety of reasons. Congenital ptosis is normally diagnosed soon after birth. The cause of congenital ptosis is often unclear; however, the most common reason is improper development of the levator muscle. Children with congenital ptosis may also develop amblyopia, strabismus, refractive errors, astigmatism, or blurred vision. Drooping of the upper eyelid may result in an asymmetrical appearance. Surgery involves tightening the levator muscle in order to elevate the eyelid to the desired position. In severe congenital ptosis, the levator muscle is extremely weak and a "sling" operation may be performed, enabling the forehead muscles to elevate the eyelids. Surgery is generally performed when the child is 3 to 5 years of age, if the ptosis is not severe. However, when the ptosis interferes with the child's vision, surgery may be performed earlier to allow proper visual development.

There are four types of acquired ptosis:<sup>12</sup>

- Aponeurogenic or involuntional: (the most common type) caused by age-related degeneration of the levator muscle and its tendon
- Myogenic: caused by muscular weakness secondary to genetic or immunological disorders such as Myasthenia Gravis
- Neurogenic: caused when the third cranial nerve control of the eyelid muscles is disrupted secondary to inflammation, infection, or demyelination as seen in Horner's syndrome
- Mechanical: caused by tumors or postinflammatory scarring disrupting levator muscle function. The ptosis may be bilateral or unilateral, and in the majority of cases it is transient

Blepharoptosis or ptosis surgery is challenging even for the most experienced plastic surgeon. Reoperation rates in most case series of acquired ptosis vary from 5% to 35%.<sup>11</sup> Surgery involves incision along the natural crease of the lid where the levator muscle can be reached and a portion of it removed. When the muscle is shortened, its elasticity is restored, and it will cause the upper eyelid to rise to its normal position. Surgery is usually indicated when the ptosis persists after the medical condition is treated or, in the case of a third nerve palsy, spontaneous recovery does not occur within six to 12 months.<sup>12</sup>

Photographic documentation of the patient looking in primary gaze, down-gaze, and side views is recommended. Visual field testing on each ptotic eyelid in primary gaze and again with the eyelids taped up will resemble the postsurgical result.

### **Brow Lift**

In cases of significant brow ptosis, a brow lift may be needed for functional reasons. Brow ptosis may accentuate upper eyelid skin redundancy. This surgery strengthens the tissues that support the brow. It can be accomplished with a forehead procedure, which will result in a less visible scar than

procedures performed on the brow itself. Brow lift may be performed alone or in combination with a blepharoplasty or blepharoptosis repair when there is significant skin overhang in the upper eyelids. In some patients a functional brow lift may be the only procedure required to correct their functional upper vision loss and will better meet their surgical goals.

Brow ptosis repair 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 upper lid blepharoplasty alone, as shown by taping and visual field testing. It is recommended the patient's brow be relaxed when assessing the eyebrow position.<sup>6,14</sup> Photographs may be taken from front, side, and oblique views to demonstrate the significance of the brow ptosis.

### Summary of Evidence

Based on the evidence of peer-reviewed literature, position statements by professional societies,<sup>2,15</sup> and governmental agency guidelines, there are specific functional indications for blepharoplasty, blepharoptosis repair, and brow repair/lift. Blue Shield of California intends to use definitions and make determinations consistent with the Reconstructive Surgery Act (AB 1621) which was added to the California Health and Safety Code (Section 1367.63), Insurance Code (Section 10123.88) and Welfare and Institutions Code (Section 14132.62).<sup>1</sup>

### References

1. Reconstructive Surgery Act (AB 1621). 1998. [http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab\\_1601-1650/ab\\_1621\\_bill\\_19980219\\_amended\\_asm.html](http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1601-1650/ab_1621_bill_19980219_amended_asm.html). Accessed February 9, 2024.
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14. American Society of Plastic Surgeons (ASPS). Practice Parameter for Blepharoplasty. March 2007. <https://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Blepharoplasty-Practice-Parameter.pdf>. Archived

## Documentation for Clinical Review

**Please provide the following documentation:**

- History and physical and/or consultation notes including (if applicable):
  - Preoperative quality photographs of the functional impairment or condition including frontal full-face views (camera at eye level and patient looking straight ahead), and other views (i.e., lateral [side] or oblique views), if applicable
  - Visual field perimetry testing with eyelids taped and untaped, including physician interpretation and documentation of the degrees of superior visual field impairment, if applicable
  - Quality photographs demonstrating functional visual impairment secondary to corticosteroid therapy, or other disease processes or metabolic or inflammatory disorders
  - Documentation of corneal disruption by eyelashes due to extra roll of pretarsal skin and orbicularis muscle
  - Documentation if required to fully demonstrate abnormal eyelid position (down-gaze, and lateral [side] views)
  - Documentation for infants or children less than nine years of age that in the judgment of the treating physician are at risk for occlusion amblyopia
  - Documentation of the eyebrow below the supraorbital rim (side and oblique views may also be required to fully demonstrate brow ptosis)

**Post Service (in addition to the above, please include the following):**

- Operative report(s)

## Coding

*This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.*

*The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.*

Type	Code	Description
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 (e.g., 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)



Type	Code	Description
	67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)
	67909	Reduction of overcorrection of ptosis
HCPCS	None	

## Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/01/2002	Adoption BSC Medical Management Guideline
09/01/2003	Developed and adapted MMG as new Medical Policy (2003)
01/01/2005	Coding Update
01/11/2008	Medical policy and literature review. Clarification of medically necessary criteria. Policy title change. Prior policy title Ocular Surgery: Blepharoplasty, Eye Lid and Brow Surgeries.
10/07/2011	Policy title change from Blepharoplasty: Eye Lid and Brow Surgeries with position change
03/30/2015	Policy clarification
05/29/2015	Coding update
09/30/2015	Policy revision without position change
07/01/2016	Policy revision without position change
07/01/2017	Policy revision without position change
07/01/2018	Policy statement clarification
08/01/2018	Policy revision without position change
10/01/2018	Policy statement clarification
07/01/2019	Policy revision without position change
04/01/2020	Administrative update. Policy statement and guidelines updated.
04/01/2021	Annual review. No change to policy statement. Documentation for Clinical Review section updated.
04/01/2022	Annual review. No change to policy statement.
06/01/2022	Administrative update.
03/01/2023	Annual review. No change to policy statement.
03/01/2024	Annual review. No change to policy statement.

## Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: [MedPolicy@blueshieldca.com](mailto:MedPolicy@blueshieldca.com)

*Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*

**Appendix A**

POLICY STATEMENT	
BEFORE <span style="color: red;">Red font: Verbiage removed</span>	AFTER
<p><b>Blepharoplasty, Blepharoptosis Repair (Levator Resection) and Brow Lift (Repair of Brow Ptosis) BSC7.01</b></p> <p><b>Policy Statement:</b>  <span style="color: red;">The California Reconstructive Surgery Act (Health &amp; Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do <b>either</b> of the following (see also Blue Shield of California Medical Policy: Reconstructive Services):</span></p> <ol style="list-style-type: none"> <li>I. <span style="color: red;">Create a normal appearance to the extent possible</span></li> <li>II. <span style="color: red;">Improve function</span></li> </ol> <p>In interpreting whether a proposed procedure meets the definition of reconstructive surgery, as defined by law, the procedure may be denied as <b>not medically necessary</b> under <b>any</b> of the following conditions:</p> <ol style="list-style-type: none"> <li>I. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery</li> <li>II. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see <a href="#">Policy Guidelines</a> and <a href="#">Documentation for Clinical Review</a> sections)</li> <li>III. There is alternative approved medical or surgical intervention with equal or superior clinical outcomes</li> <li>IV. The procedure is for <a href="#">cosmetic</a> purposes only</li> </ol> <p><b>Upper Eyelid Blepharoplasty</b>                      Unilateral or bilateral (see Policy Guidelines) upper eyelid blepharoplasty may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:</p> <ol style="list-style-type: none"> <li>I. The issue involves one or both eyes</li> </ol>	<p><b>Blepharoplasty, Blepharoptosis Repair (Levator Resection) and Brow Lift (Repair of Brow Ptosis) BSC7.01</b></p> <p><b>Policy Statement:</b></p> <p>In interpreting whether a proposed procedure meets the definition of reconstructive surgery, as defined by law, the procedure may be denied as <b>not medically necessary</b> under <b>any</b> of the following conditions:</p> <ol style="list-style-type: none"> <li>I. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery</li> <li>II. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see <a href="#">Policy Guidelines</a> and <a href="#">Documentation for Clinical Review</a> sections)</li> <li>III. There is alternative approved medical or surgical intervention with equal or superior clinical outcomes</li> <li>IV. The procedure is for <a href="#">cosmetic</a> purposes only</li> </ol> <p><b>Upper Eyelid Blepharoplasty</b></p> <ol style="list-style-type: none"> <li>I. Unilateral or bilateral (see Policy Guidelines) upper eyelid blepharoplasty may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:                             <ol style="list-style-type: none"> <li>A. The issue involves one or both eyes</li> </ol> </li> </ol>

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<p>II. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</p> <p>III. The office notes demonstrate functional visual impairment with <b>both</b> of the following:</p> <p>A. Visual field perimetry testing demonstrating <b>both</b> of the following:</p> <ol style="list-style-type: none"> <li>1. Superior visual field impairment within 30 degrees (untaped)</li> <li>2. After lid taping, correction of the defect and restoration of the normal central vision field</li> </ol> <p>B. Preoperative quality photographic evidence clearly showing the problem (e.g., frontal, down gaze, oblique or side views as needed) including <b>both</b> of the following:</p> <ol style="list-style-type: none"> <li>1. Before lid taping with the camera at eye level and patient in the straight gaze position</li> <li>2. Demonstration of the true lid margin or the pseudo-lid margin</li> </ol> <p>Unilateral or bilateral upper eyelid blepharoplasty for a patient with an eyelid pathology that impacts visual function (other than field of vision) in at least one eye, may be considered <b>medically necessary</b> to treat <b>any</b> of the following:</p> <ol style="list-style-type: none"> <li>I. Intractable pain caused by blepharospasm</li> <li>II. To preserve corneal function (due to severe ectropion, entropion, or corneal exposure)</li> <li>III. To correct congenital disease affecting visual development</li> <li>IV. To compensate for overall functional effects caused by trauma or as a result of tumor removal</li> <li>V. To treat severe peri-orbital dysfunction caused by nerve paralysis or thyroid disorders</li> </ol> <p>Unilateral or bilateral upper eyelid blepharoplasty may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:</p> <ol style="list-style-type: none"> <li>I. The issue involves one or both eyes</li> </ol>	<p>B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</p> <p>C. The office notes demonstrate functional visual impairment with <b>both</b> of the following:</p> <ol style="list-style-type: none"> <li>1. Visual field perimetry testing demonstrating <b>both</b> of the following: <ol style="list-style-type: none"> <li>a. Superior visual field impairment within 30 degrees (untaped)</li> <li>b. After lid taping, correction of the defect and restoration of the normal central vision field</li> </ol> </li> <li>2. Preoperative quality photographic evidence clearly showing the problem (e.g., frontal, down gaze, oblique or side views as needed) including <b>both</b> of the following: <ol style="list-style-type: none"> <li>a. Before lid taping with the camera at eye level and patient in the straight gaze position</li> <li>b. Demonstration of the true lid margin or the pseudo-lid margin</li> </ol> </li> </ol> <p>II. Unilateral or bilateral upper eyelid blepharoplasty for a patient with an eyelid pathology that impacts visual function (other than field of vision) in at least one eye, may be considered <b>medically necessary</b> to treat <b>any</b> of the following:</p> <ol style="list-style-type: none"> <li>A. Intractable pain caused by blepharospasm</li> <li>B. To preserve corneal function (due to severe ectropion, entropion, or corneal exposure)</li> <li>C. To correct congenital disease affecting visual development</li> <li>D. To compensate for overall functional effects caused by trauma or as a result of tumor removal</li> <li>E. To treat severe peri-orbital dysfunction caused by nerve paralysis or thyroid disorders</li> </ol> <p>III. Unilateral or bilateral upper eyelid blepharoplasty may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:</p>

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<p>II. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</p> <p>III. Ophthalmic prosthesis appearance is affected by excess eyelid skin</p> <p><b>Lower Eyelid Blepharoplasty</b> Unilateral or bilateral lower eyelid blepharoplasty may be considered <b>medically necessary</b> to treat an individual with <b>ALL</b> the following:</p> <ol style="list-style-type: none"> <li>I. The issue involves one or both eyes</li> <li>II. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</li> <li>III. The office notes provide preoperative quality photographs clearly showing the problem (e.g., frontal, down gaze, oblique or lateral views as needed) with <b>either</b> of the following:                     <ol style="list-style-type: none"> <li>A. Massive lower eyelid edema causing functional visual impairment secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome, or other metabolic or inflammatory disorders</li> <li>B. Epiblepharon or entropion in which an extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea</li> </ol> </li> </ol> <p><b>Upper Eyelid Blepharoptosis/Ptosis Repair (Levator Resection)</b> Unilateral or bilateral upper eyelid blepharoptosis/ptosis repair may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:</p> <ol style="list-style-type: none"> <li>I. The issue involves one or both eyes</li> <li>II. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</li> </ol>	<ol style="list-style-type: none"> <li>A. The issue involves one or both eyes</li> <li>B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</li> <li>C. Ophthalmic prosthesis appearance is affected by excess eyelid skin</li> </ol> <p><b>Lower Eyelid Blepharoplasty</b></p> <p>IV. Unilateral or bilateral lower eyelid blepharoplasty may be considered <b>medically necessary</b> to treat an individual with <b>ALL</b> the following:</p> <ol style="list-style-type: none"> <li>A. The issue involves one or both eyes</li> <li>B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</li> <li>C. The office notes provide preoperative quality photographs clearly showing the problem (e.g., frontal, down gaze, oblique or lateral views as needed) with <b>either</b> of the following:                     <ol style="list-style-type: none"> <li>1. Massive lower eyelid edema causing functional visual impairment secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome, or other metabolic or inflammatory disorders</li> <li>2. Epiblepharon or entropion in which an extra roll of pretarsal skin and orbicularis muscle deflects the eyelashes against the cornea</li> </ol> </li> </ol> <p><b>Upper Eyelid Blepharoptosis/Ptosis Repair (Levator Resection)</b></p> <p>V. Unilateral or bilateral upper eyelid blepharoptosis/ptosis repair may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:</p> <ol style="list-style-type: none"> <li>A. The issue involves one or both eyes</li> <li>B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</li> </ol>

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<p>III. The office notes document that at least one eye meets <b>both</b> of the following:</p> <ul style="list-style-type: none"> <li>A. Visual field perimetry testing demonstrating <b>both</b> of the following:                             <ul style="list-style-type: none"> <li>1. Superior visual field impairment within 30 degrees (untaped)</li> <li>2. After lid taping, correction of the defect and restoration of the normal central vision field</li> </ul> </li> <li>B. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem including <b>both</b> of the following:                             <ul style="list-style-type: none"> <li>1. Before lid taping with the camera at eye level and patient in the straight gaze position</li> <li>2. Demonstration of abnormal upper eyelid position, including ptosis encroaching upon the pupillary border</li> </ul> </li> </ul> <p><b>Unilateral or Bilateral Blepharoptosis/Ptosis Repair (Levator Resection)</b>                      Unilateral or bilateral blepharoptosis/ptosis repair (levator resection) may be considered <b>medically necessary</b> for infants or children younger than 18 years of age meeting <b>any</b> following criteria:</p> <ul style="list-style-type: none"> <li>I. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem with <b>either</b>:                             <ul style="list-style-type: none"> <li>A. An appearance that is outside the range of normal seen in large populations</li> <li>B. An impairment or condition in an individual less than nine years of age who in the judgment of the treating physician is at risk for occlusion amblyopia</li> </ul> </li> <li>II. The appearance is not clearly outside the range of normal, but a significant functional abnormality (related to ptosis) is documented by either visual field testing or other findings on exam (confrontation fields, head positioning, etc.)</li> </ul> <p><b>Brow Lift</b>                      Unilateral or bilateral brow lift/brow ptosis repair may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:</p>	<p>C. The office notes document that at least one eye meets <b>both</b> of the following:</p> <ul style="list-style-type: none"> <li>1. Visual field perimetry testing demonstrating <b>both</b> of the following:                             <ul style="list-style-type: none"> <li>a. Superior visual field impairment within 30 degrees (untaped)</li> <li>b. After lid taping, correction of the defect and restoration of the normal central vision field</li> </ul> </li> <li>2. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem including <b>both</b> of the following:                             <ul style="list-style-type: none"> <li>a. Before lid taping with the camera at eye level and patient in the straight gaze position</li> <li>b. Demonstration of abnormal upper eyelid position, including ptosis encroaching upon the pupillary border</li> </ul> </li> </ul> <p><b>Unilateral or Bilateral Blepharoptosis/Ptosis Repair (Levator Resection)</b>                      VI. Unilateral or bilateral blepharoptosis/ptosis repair (levator resection) may be considered <b>medically necessary</b> for infants or children younger than 18 years of age meeting <b>any</b> following criteria:</p> <ul style="list-style-type: none"> <li>A. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem with <b>either</b>:                             <ul style="list-style-type: none"> <li>1. An appearance that is outside the range of normal seen in large populations</li> <li>2. An impairment or condition in an individual less than nine years of age who in the judgment of the treating physician is at risk for occlusion amblyopia</li> </ul> </li> <li>B. The appearance is not clearly outside the range of normal, but a significant functional abnormality (related to ptosis) is documented by either visual field testing or other findings on exam (confrontation fields, head positioning, etc.)</li> </ul> <p><b>Brow Lift</b>                      VII. Unilateral or bilateral brow lift/brow ptosis repair may be considered <b>medically necessary</b> for an individual with <b>ALL</b> of the following:</p>

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<ul style="list-style-type: none"> <li>I. The issue involves one or both eyes</li> <li>II. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</li> <li>III. The office notes document <b>both</b> of the following:                             <ul style="list-style-type: none"> <li>A. Visual field perimetry testing demonstrating <b>both</b> of the following:                                     <ul style="list-style-type: none"> <li>1. Superior visual field impairment within 30 degrees (untaped)</li> <li>2. After lid taping, correction of the defect and restoration of the normal central vision field</li> </ul> </li> <li>B. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem including <b>both</b> of the following:                                     <ul style="list-style-type: none"> <li>1. Before lid taping with the camera at eye level and patient in the straight gaze position</li> <li>2. Demonstration of the eyebrow below the supraorbital rim</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. The issue involves one or both eyes</li> <li>B. The purpose is to correct, or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to create a normal appearance to the extent possible or improve function</li> <li>C. The office notes document <b>both</b> of the following:                             <ul style="list-style-type: none"> <li>1. Visual field perimetry testing demonstrating <b>both</b> of the following:                                     <ul style="list-style-type: none"> <li>a. Superior visual field impairment within 30 degrees (untaped)</li> <li>b. After lid taping, correction of the defect and restoration of the normal central vision field</li> </ul> </li> <li>2. Preoperative quality photographs (e.g., frontal, down gaze, oblique or lateral views as needed) clearly showing the problem including <b>both</b> of the following:                                     <ul style="list-style-type: none"> <li>a. Before lid taping with the camera at eye level and patient in the straight gaze position</li> <li>b. Demonstration of the eyebrow below the supraorbital rim</li> </ul> </li> </ul> </li> </ul>