

<b>Medical Benefit</b>		<b>Effective Date:</b> 01/01/13	<b>Next Review Date:</b> 05/18
<b>Preauthorization</b>	No	<b>Review Dates:</b> 09/12, 09/13, 09/14, 09/15, 09/16, 05/17	

***Preauthorization is encouraged for reconstructive services.***

*The following protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient's contract at the time the services are rendered.*

### Description

Blepharoplasty may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance and may be either reconstructive or cosmetic (aesthetic).

### Policy

Blepharoplasty\* may be considered **medically necessary** when performed for one of the following:

- To correct visual impairment caused by:
  - Dermatochalasis, including symptomatic redundant skin weighing down on the upper eyelashes (i.e., pseudoptosis) and surgically induced dermatochalasis after ptosis repair.
  - Blepharochalasis.
  - Acquired blepharoptosis, including dehiscence of the aponeurosis of the levator palpebrae superioris muscle after trauma or cataract extraction, causing ptosis that may obstruct the superior visual field as well as the visual axis in downgaze (reading position).
  - Brow ptosis. It is recognized that brow ptosis repair, in addition to blepharoplasty and/or blepharoptosis repair, may be necessary in some cases to provide an adequate functional result.

Canthoplasty\* is considered **medically necessary** as part of a **medically necessary** blepharoplasty procedure to correct eyelids that sag so much that they pull down the upper eyelid so that vision is obstructed.

Any procedure(s) involving blepharoplasty must be needed because the member has complaints which justify **functional** surgery. The complaints must be those signs and symptoms commonly found in association with ptosis, pseudoptosis, blepharochalasis and/or dermatochalasis. These include (but are not limited to):

- Significant interference with vision or superior or lateral visual field, (e.g., difficulty seeing objects approaching from the periphery);
- Difficulty reading due to superior visual field loss; or,
- Looking through the eyelashes or seeing the upper eyelid skin.

The visual fields should demonstrate a significant loss of superior visual field and potential correction of the visual field by the proposed procedure(s). A minimum 12 degree or 30 percent loss of upper field of vision with upper lid skin and/or upper lid margin in repose and elevated (by taping of the lid) to demonstrate potential correction by the proposed procedure or procedures is required. (See Policy Guidelines) Photographs should also demonstrate the eyelid abnormality(ies) necessitating the procedure(s). (See Policy Guidelines)

In the case of prosthetic difficulties associated with an anophthalmic, microphthalmic, or enophthalmic socket, subjective complaints, examination findings (signs), and failure of prosthesis modification (when indicated) must exist. **Photos must demonstrate** the contribution of one of the above mentioned orbital and/or globe abnormalities as they relate to the abnormal upper and/or lower eyelid position and intolerance of prosthesis wear. (See Policy Guidelines)

2. Repair of anatomical or pathological defects, including those caused by disease (including thyroid dysfunction and cranial nerve palsies), trauma, or tumor-ablative surgery. Surgery is performed to reconstruct the normal structure of the eyelid, using local or distant tissue. Reconstruction may be necessary to protect the eye and/or improve visual function.

Examples:

- Epiblepharon\*
- Post-traumatic defects of the eyelid
- Post-surgical defects after excision of neoplasm(s)
- Lagophthalmos
- Congenital lagophthalmos\*
- Congenital ptosis\* (moderate to severe ptosis: in infants and children this is medically necessary to allow proper visual development and prevent amblyopia; treatment of mild congenital ptosis is not medically necessary)
- Lid retraction or lag (due to horizontal lower eyelid laxity without ectropion or entropion, causing exposure keratopathy and/or epiphora; due to horizontal upper eyelid laxity, causing floppy eyelid syndrome; or due to orbital thyroid disease)
- Chronic symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin.

The medical record must contain documented patient complaints and pertinent examination findings to justify the medical necessity for **functional**, restorative procedure(s) for the treatment of any of the above conditions. In addition, photographic documentation must demonstrate the clinical abnormality(ies) consistent with the member's subjective complaint(s) for asterisked (\*) diagnoses listed above.

3. *Relief of eye symptoms associated with blepharospasm.* Primary essential (idiopathic) blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periocular facial muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated, a blepharoplasty combined with limited myectomy may be necessary.

## Policy Guidelines

### Definitions

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

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

Blepharoptosis: Drooping of the upper eyelid which relates to the position of the eyelid margin with respect to the eyeball and visual axis.

Pseudoptosis: "False ptosis," for the purposes of this protocol, describes the specific circumstance when the eyelid margin is usually in an appropriate anatomic position with respect to the eyeball and visual axis but the amount of excessive skin from dermatochalasis or blepharochalasis is so great as to overhang the eyelid margin and create its own ptosis. Other causes of pseudoptosis, such as hypotropia and globe malposition, are managed differently and do not apply to this protocol. Pseudoptosis resulting from insufficient posterior support of the eyelid, as in phthisis bulbi, microphthalmos, congenital or acquired anophthalmos, or enophthalmos is often correctable by prosthesis modification when a prosthesis is present, although persistent ptosis may be corrected by surgical ptosis repair.

Brow Ptosis: Drooping of the eyebrows to such an extent that excess tissue is pushed into the upper eyelid. It is recognized that in some instances the brow ptosis may contribute to significant superior visual field loss. It may coexist with clinically significant dermatochalasis and/or lid ptosis.

Horizontal Eyelid Laxity: Poor eyelid tone, usually a result of the aging process, that causes lid retraction without frank ectropion formation but with corneal exposure and irritation (foreign body sensation) and dysfunction of the eyelid "lacrimal pump," both of which result in symptomatic tearing (epiphora).

***This protocol does not address entropion and ectropion repair.***

The following are all applicable for determining visual impairment that requires medically necessary blepharoplasty:

*Visual fields* must be recorded using either a tangent screen visual field, Goldmann Perimeter (III 4-E test object), or a programmable automated perimeter, equivalent to a screening field with a single intensity strategy using a 10dB stimulus, to test a superior (vertical) extent of 50-60 degrees above fixation with targets presented at a minimum four-degree vertical separation starting at zero (0) degrees above fixation while using no wider than a 10-degree horizontal separation.

- Each eye should be tested with the upper eyelid at rest and repeated with the lid elevated (e.g., taped or manually retracted) to demonstrate an expected "surgical" improvement meeting or exceeding the criteria. As previously stated, visual fields must demonstrate a minimum 12 degrees or 30 percent loss of upper field of vision with upper lid skin and/or upper lid margin in repose and elevated (by taping of the lid) to demonstrate potential correction by the proposed procedure or procedures.
- Visual field studies must be labeled with the member's name, the date, and the eye tested. If the skin edge is below the true eyelid margin, the visual field must be performed with the excess skin untaped and taped (or otherwise retracted).
- For ptosis in isolation or concurrent with dermatochalasis, the visual fields should be repeated with the true eyelid taped such that the eyelid margin assumes the anatomic position.

#### **AND**

*Photographs, including marginal reflex distance* (prints, not slides) must be frontal and canthus-to-canthus with the head perpendicular to the plane of the camera (i.e., not tilted) in order to demonstrate the position of the true lid margin or the "false lid margin" in the case of pseudoptosis caused by severe dermatochalasis. The photographs must be of sufficient clarity to show a light reflex on the cornea or the relationship of the eyelid to the cornea or pupil (except in cases where the lid margin obscures the corneal light reflex or a digital camera is used and there is no light reflex).

Photographs for the purpose of justifying an eyelid procedure(s) and/or brow ptosis procedure(s) due to superior visual field loss must demonstrate that the upper eyelid margin approaches to within 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex.

Specific photograph requirements are:

Blepharoplasty must portray both eyelids in the frontal (straight-ahead) position demonstrating:

- Upper eyelid skin resting on the eyelashes or over the eyelid margin; or,
- Excessive dermatochalasis pushing the eyelid margin down to an abnormally low position; or,
- One of the above in cases of the induction of visually compromising dermatochalasis after ptosis repair in patents having a large dehiscence of the levator aponeurosis.

Blepharoptosis repair must portray both eyelids in the frontal (straight-ahead) position demonstrating:

- True lid ptosis;
- The upper eyelid position with respect to prosthesis in an anophthalmic socket or to the globe in congenital or acquired microphthalmos or in enophthalmos.

Blepharoptosis repair and blepharoplasty must portray both eyelids in the frontal (straight-ahead) position demonstrating:

- Presence of true lid ptosis when excessive skin is elevated by taping or is otherwise retracted, especially if it lies below the position of the true eyelid margin. Oblique or lateral photographs may be required to demonstrate redundant skin on the eyelashes.

Brow ptosis (performed singly or in combination with other procedures) must be frontal demonstrating:

- Drooping of brows below the superior orbital rim; and,
- Improvement of blepharoptosis and/or dermatochalasis by elevation of the brows. **Note:** If a blepharoplasty and/or lid ptosis repair and/or brow ptosis are planned, the **medical necessity** for each individual procedure must be met, including the supportive photographs. This may require multiple sets of photographs (and/or visual fields), showing the effect of drooping of redundant skin (and its correction by taping or manual retraction) and the actual presence of blepharoptosis and/or brow ptosis and/or an eyelid dermatitis.

If the member's only complaint is obstruction of vision when reading, two photographs are required to show the eyelid position in primary gaze (straight ahead) and downgaze (visual axis and camera lens coaxial), demonstrating:

- The eyelid position in primary gaze (straight ahead) and down gaze (visual axis and camera lens coaxial); and,
- The subjective complaints of the member must be well documented in the medical record as well as the medical and/or surgical history supporting eyelid dysfunction. For instance, many members may not have problems until after fatigue and/or may have more problems in the afternoon compared to the morning.

In cases of induction of visually compromising dermatochalasis by ptosis repair in members having large dehiscence of the levator aponeurosis, the medical information must demonstrate large dehiscence of the levator aponeurosis.

## Background

Upper blepharoplasty and/or repair of blepharoptosis may be considered functional in nature when excess upper eyelid tissue or the upper lid position produces functional complaints. Those functional complaints are usually related to visual field impairment in primary gaze and/or down gaze (e.g., reading position). The visual impairment is commonly related to a lower than normal position of the eyelid relative to the pupil and/or to excess skin that hangs over the edge of the eyelid. Other functional complaints may be chronic dermatitis due to redundant skin and anophthalmic socket in patients with prosthesis difficulties. Brow ptosis may also produce or contribute to functional visual field impairment. Similarly, surgery of the lower eyelids is reconstructive when poor eyelid tone (with or without entropion or ectropion) causes dysfunction of the “lacrimal pump,” lid retraction, and/or exposure keratoconjunctivitis that often results in epiphora (tearing).

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Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. *For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.*

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. **Some of this protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.**

## References

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.

1. National Government Services, Inc. Local Coverage Article: Blepharoplasty - Medical Policy Article (A52837), Revision Effective Date 10/01/2015.
2. Corporate Medical Protocol Cosmetic vs. Reconstructive Surgery or Services, 07/01/15.