UnitedHealthcare®

Reimbursement Policy

Blepharoplasty

Policy Number	BLE07092014RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	07/09/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. CPT codes and descriptions are copyright 2010 American Medical Association (or such other date of publication of CPT). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to Government use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Current Dental Terminology (CDT), including procedure codes, nomenclature, descriptors, and other data contained therein, is copyright by the American Dental Association, 2002, 2004. All rights reserved. CDT is a registered trademark of the American Dental Association. Applicable FARS/DFARS apply.

Summary

Overview

Medicare does not cover cosmetic surgery or expenses incurred in connection with such surgery. Cosmetic surgery is defined by Medicare as: “any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose” (CMS Publication 100-2; Medicare Benefit Policy Manual, Chapter 16, Section 120). This reimbursement policy provides additional guidance on covered indications and limitations of coverage for blepharoplasty surgery.

The American Society of Plastic and Reconstructive Surgeons has published the following definitions:

- Blepharoplasty may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. It may be either reconstructive or cosmetic (aesthetic).
- Cosmetic Blepharoplasty: When blepharoplasty is performed to improve a patient’s appearance in the absence of any signs or symptoms of functional abnormalities, the procedure is considered cosmetic.
- Reconstructive Blepharoplasty: When blepharoplasty is performed to correct visual impairment caused by drooping of the eyelids (ptosis); repair defects caused by trauma or tumor-ablative surgery (ectropion/entropion corneal exposure); treat periorbital sequelae of thyroid disease and nerve palsy; or relieve the painful symptoms of blepharospasm, the procedure should be considered reconstructive. This may involve rearrangement or excision of the structures with the eyelids and/or tissues of the cheek, forehead and nasal areas. Occasionally a graft of skin or other distant tissues is transplanted to replace deficient eyelid components.

Blepharoplasty, blepharoptosis and lid reconstruction may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. They may be either functional/reconstructive or cosmetic. Upper blepharoplasty (removal of upper eyelid skin) and/or repair of blepharoptosis should be considered functional/reconstructive in nature when the upper lid position or overhanging skin or brow is sufficiently low to produce functional complaints, usually related to visual field impairment whether in primary gaze or down-gaze reading position. Upper blepharoplasty may also be indicated for chronic dermatitis due to redundant skin. Another indication for blepharoptosis surgery is patients with an anophthalmic socket experiencing ptosis or prosthesis difficulties. Brow ptosis (i.e., descent or droop of the eyebrows) can also produce or contribute to functional impairment. Either or both of these procedures may be required in some situations when a blepharoplasty would not result in a satisfactory functional repair. 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).

Reimbursement Guidelines

The criteria in section A (patient signs and symptoms), section B (photographs), and section C (visual field) below must be documented to demonstrate medical necessity.

A. Documentation in the medical records must include patient complaints and findings secondary to eyelid or brow malposition such as:

1. Interference with vision or visual field, related to activities such as, difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue.
2. Chronic eyelid dermatitis due to redundant skin.
3. Difficulty wearing prosthesis.
4. Margin reflex distance (MRD) of 2.5 mm or less. (The margin reflex distance is a measurement from the corneal light reflex to the upper eyelid margin with the brows relaxed.)
5. A palpebral fissure height on down-gaze of 1 mm or less. (The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated.)
6. The presence of Herring's effect meeting one of the above two (#4 or 5) criteria. (Herring's law is one of equal innervation to both upper eyelids and is considered in the documentation to perform bilateral ptosis in which the position of one upper eyelid has marginal criteria and the other eyelid has good supportive documentation for ptosis surgery. In these cases, the surgeon can lift the more ptotic lid with tape or instillation of Phenylepherine drops into the superior formix. If the less ptotic lid then drops downward according to Herring's law to the point of an MRD of 2.5 mm or less or a down-gaze MRD of 1.5 or less or a palpebral fissure width on down-gaze of 1 mm or less, then the less ptotic lid would be considered for surgical correction.)

B. Photographs and medical record documentation must demonstrate at least one of the following: (Digital or film photographs are acceptable.)

1. For Blepharoptosis Repair: Photographs of both eyelids in the frontal, straight-ahead position and/or down-gaze should be taken as appropriate.
2. For Blepharoplasty Repair: Frontal photos are needed to demonstrate redundant skin on the upper eyelids.
   - **a.** Upper eyelid skin resting on the eyelashes or over eyelid margin
   - **b.** Upper eyelid dermatitis secondary to redundant ski
   - **c.** Dermatochalasis
3. For Brow Ptosis Repair: Photographs should document medical necessity for brow ptosis repair (drooping of brows). Frontal photographs are necessary.

C. Visual fields

1. The indication for surgery is supported if a difference of 12º or more or 30% superior visual field difference is demonstrated between visual field testing before and after manual elevation of the eyelids.
2. Visually significant brow ptosis may be documented by visual field testing with the brow elevated demonstrating a difference of 12º or more or 30% superior visual field difference.
3. Visual fields need to meet accepted quality standards, whether they are performed by
4. Goldmann technique or by use of a standardized automated technique.
5. Visual fields are not necessary for patients with an anophtholmic socket who is experiencing ptosis of difficulty with their prosthesis

D. 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. Conditions that may require blepharoplasty, ptosis repair, ectropion repair, or entropion repair are:

- Ectropion and entropion

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- Epiblepharon
- Post-traumatic defects of the eyelid
- Post-surgical defects after excision of neoplasm(s)
- Lagophthalmos
- Congenital lagophthalmos
- Congenital ectropion, entropion
- Congenital ptosis
- 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 procedures(s) for the treatment of any of the above conditions. (Photography for purposes of documentation is not separately reportable or reimbursed.)

E. Relief of eye symptoms associated with blepharospasm. Primary essential idiopathic blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated (i.e., an injection of Botulinum Toxin A,) an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary.

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

Documentation Requirements

1. The patient medical records should be legible, contain the relevant history and physical findings conforming to the criteria stated in sections A-E of this policy. Copies of the following must be made available on request:

a. Pre-operative exam,
b. Photographs,
c. Visual fields with physician interpretation, and
d. Operative report.

2. Physician‘s Services and diagnostic tests must be submitted with an ICD-9 code to support the medical necessity for the service and must be coded to the greatest level of accuracy and highest level of digit completeness. This means the precise ICD-9 code that fully explains the narrative description of the diagnosis contained in the medical record or the test interpretation and report including the 4th or 5th digit sub-classification for the diagnosis category. The ICD-9 code based on the results of the test should be the primary diagnosis. If the diagnostic test results are normal or inconclusive the ICD-9 code representing the sign, symptom, illness or injury prompting the ordering of the test should be reported as the primary diagnosis. In the absence of signs, symptoms, illness or injury resulting in a functional anomaly of the upper eyelids a cosmetic (V50.1) diagnosis should be reported, and payment will be denied.

3. Operative note(s) for surgical procedures performed in the office location may be contained in the patient's medical record for the date of service or as a separate report maintained within the patient‘s chart. The operative note for the procedure performed must be of significant detail to support the surgical procedure billed. The surgical technique used should be described.

4. It is at the performing physician’s discretion to determine the level of exam he/she chooses to perform based on the patient’s condition and needs. The documentation contained in the patient’s medical record must meet the visual exam criteria stated in this policy and must support the level of visual field exam billed to Medicare.

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Blepharoplasty

CPT / HCPCS Codes

Code	Description
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)

Modifiers

Code	Description
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
59	Distinct Procedural Service

ICP / PCS Codes

Blepharoplasty ICP-PCS Coding.pdf

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Blepharoplasty

Questions and Answers

1	Q:	What does cosmetic exclusion mean?
	A:	General Exclusions From Coverage; Cosmetic Surgery (CMS Benefit Policy Manual, Chapter 16, Section 120) states: "Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose."
2	Q:	Is prior notification required?
	A:	Yes, for inpatient and outpatient surgery CPT codes 15820,15821,15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, and 67911 require prior notification.

References Included (but not limited to):

CMS LCD(s)

Numerous LCDs

CMS Article

One Article

CMS Benefit Policy Manual

Chapter 16; § 20 Services Not Reasonable and Necessary, § 120 Cosmetic Surgery

UnitedHealthcare Medicare Advantage Coverage Summaries

Blepharoplasty

Cosmetic and Reconstructive Procedures

UnitedHealthcare Reimbursement Policies

Cosmetic and Reconstructive Services and Procedures

UnitedHealthcare Coverage Determination Guidelines (CDGs)

Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair

Cosmetic and Reconstructive Procedures

Others

Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 5 Correct Coding Initiative, CMS Website

Social Security Act (Title XVIII) Standard References:

- § 1862 (a)(1)(A) Medically Reasonable & Necessary, (a)(10) Cosmetic Surgery

History

Date	Revisions
09/17/2014	Removed liability modifier references
07/09/2014	New Reimbursement Policy; Effective 07/09/2014

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