Medica Central Utilization Management Policy

Title:	**Blepharoplasty, Blepharoptosis Repair, and Brow Lift MP9664 (III-SUR.29)**
Effective Date:	**April 01, 2025**

This policy was developed with input from specialists in plastic surgery and ophthalmology and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

BACKGROUND

Definitions

A. **Blepharoplasty** is a procedure involving the surgical removal of redundant skin, muscle and fatty tissue from the eyelids for the purpose of improving abnormal function (e.g., repair excess tissue that obstructs the visual field), reconstructing deformities, or enhancing appearance.
B. **Blepharoptosis** is a droop or displacement of one or both upper eyelids.
C. **Blepharospasm** is involuntary spasmodic contraction of the orbicularis oculi muscle; may occur in isolation or be associated with other dystonic contractions of facial, jaw, or neck muscles. A variant, myokymia, is usually initiated or aggravated by emotion, fatigue, or drugs.
D. **Brow lift**, also known as a forehead lift, surgically corrects brow ptosis. It reduces wrinkle lines across the forehead, improves frown lines between the eyebrows, raises sagging

eyebrows that are hooding the upper eyelids and places the eyebrow in an alert and youthful position.

E. **Browpexy** is a suture suspension of the brow to the underlying bone. It can be performed from within the eyelid (internal brow lift) or from a small incision above the brow (external brow lift). This procedure minimally elevates or stabilizes the brow so that it will not be lowered even further when eyelid surgery is performed. This is generally performed through the same incision as the eyelid surgery. Generally done to improve appearance, or to clear the visual axis.

F. **Brow ptosis** is the laxity of the forehead muscles and sagging tissue of the eyebrows and/or forehead.

G. **Dermatochalasia** is redundancy of upper eyelid skin.

H. **Ectropion** is an eyelid dysfunction that occurs when the eyelid turns outward and does not protect the eye. As a result, the cornea and conjunctiva may become exposed and irritated. Ectropion generally affects only the lower eyelid.

I. **Entropion** is an eyelid dysfunction that occurs when the eyelid turns inward towards the eye, causing the lid and eyelashes to rub against the cornea and conjunctiva causing irritation and discomfort. Entropion generally affects only the lower eyelid, but upper eyelids are sometimes affected.

J. **Marginal Reflex Distance (MRD)** is a measurement that assesses the distance from the apparent center (visual axis) of the pupil to the upper lid**.** A MRD measurement that is greater than or equal to 2.5 millimeters is considered normal. Superior visual field impairment is nearly universal when the MRD is less than or equal to 2.0 millimeters. The MRD is the most useful measure for predicting visual field impairment.

K. **Ptosis** is drooping of the upper eyelids that cause the margin to rest at a position lower than normal. Ptosis may be classified as either “true ptosis” (lack of eyelid support) or “pseudo ptosis” (presence of excess lid tissue). Ptosis may be unilateral, bilateral, congenital, or acquired and may impair the superior vision field

BENEFIT CONSIDERATIONS

1. Prior authorization is required for blepharoplasty (upper or lower eyelid), blepharoptosis repair (upper eyelid) and brow lift. Please see the prior authorization list for product specific prior authorization requirements.
2. Ectropion/entropion surgical repair does not require prior authorization as they are considered medically necessary.
3. Coverage may vary according to the terms of the member’s plan document.
4. Cosmetic surgery is generally an exclusion in the member’s plan document.
5. If two or more procedures (one cosmetic and one reconstructive) are performed during the same operative session, the surgeon must delineate the cosmetic and reconstructive components associated with the procedure. All services associated with the cosmetic component (e.g., anesthesia fees) are normally considered excluded services per terms of the member’s plan document.
6. If the below medical necessity criteria are not met, the procedure(s) would be considered cosmetic.
7. For congenital ptosis refer to the reconstructive definition in the member’s plan document.
8. If the Medical Necessity Criteria and Benefit Considerations are met, Medica will authorize benefits within the limits in the member’s plan document.
9. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Provider Administrative Manual.

MEDICAL NECESSITY CRITERIA

I. Indications for blepharoplasty (upper)
Blepharoplasty (upper) is considered medically necessary when documentation in the medical records indicates **all of the following** criteria are met:
A. The member has **one of the following** functional deficiencies:
1. Defect caused by trauma or tumor-ablative surgery
2. Periorbital sequelae of thyroid disease and nerve palsy
3. Painful symptoms of blepharospasm
4. Chronic eyelid dermatitis due to redundant skin refractory to medical therapy
5. Visual impairment caused by abnormal or redundant upper eyelid structures as demonstrated by **all of the following**:
a. Excess upper eyelid skin touches the lashes
b. Visual field testing, with the eyelids taped and untaped, showing improvement of at least 12 degrees or 30 percent or more in number of points seen.
B. No documented medical conditions where blepharoplasty is unlikely to correct visual field (e.g., myasthenia gravis, recent botulinum injections in the past six months).
C. Documentation in the medical records indicates **all of the following**:
1. A frontal, straight-ahead photograph showing that the excess skin touches the lashes, and/or side photographs.
2. Diagnosis and description of functional impairment that relates to the need for blepharoplasty.
3. Interpretation of visual field testing.

Note: For members with unilateral disease meeting criteria for the above-listed procedures, surgery of the contralateral eye may be considered medically necessary to obtain symmetry.

II. Indications for blepharoptosis repair (ptosis repair of upper eyelid includes levator resection or advancement)
Blepharoptosis repair is considered medically necessary when documentation in the medical records indicates **all of the following** criteria are met:
A. The member has a MRD measurement of less than or equal to 2.5 mm with the brow relaxed.
B. No documented medical conditions where blepharoptosis repair is unlikely to correct visual field (e.g., untreated myasthenia gravis, recent botulinum injections in the past six months).
C. Documentation in the medical records indicates **all of the following**:
1. A frontal, straight-ahead photograph showing the abnormal lid droop/displacement
2. Diagnosis and description of functional impairment that relates to the need for blepharoptosis repair.

Note: For members with unilateral disease meeting criteria for the above-listed procedures, surgery of the contralateral eye may be considered medically necessary if it will cause contralateral lid droop (e.g., Herrings effect).

III. Indications for brow lift
NOTE: Brow lift and browpexy are generally considered cosmetic and require medical director review.

Brow lift is considered medically necessary when documentation in the medical records indicates that **all of the following** criteria are met:
A. Visual impairment caused by brow malposition as indicated by eyebrow descent below the level of the superior orbital rim.
B. Visual impairment cannot be corrected by blepharoplasty alone
C. No documented medical conditions where brow lift is unlikely to correct visual field (e.g., untreated myasthenia gravis, recent botulinum injections in the past six months).
D. Documentation in the medical records indicates **all of the following**:

1. Documentation states why the functional visual impairment cannot be corrected by blepharoplasty alone and/or blepharoptosis repair.
2. Diagnosis and description of functional impairment that relates to the need for a brow lift
3. A frontal, straight-ahead photograph showing eyebrow descent below the level of the superior orbital rim, and/or side photographs.

Note: For members with unilateral disease meeting criteria for the above-listed procedures, surgery of the contralateral eye may be considered medically necessary to obtain symmetry.

IV. Indications for blepharoplasty (lower)

NOTE: Lower lid blepharoplasty is generally considered cosmetic and requires medical director review.

Blepharoplasty (lower) is considered medically necessary when documentation in the medical records indicates that **all of the following** criteria are met:

A. The member has **one of the following**:
   1. Defect caused by trauma or tumor-ablative surgery
   2. Massive lower eyelid edema secondary to systemic corticosteroid therapy, myxedema, Graves' disease, nephrotic syndrome, or other metabolic or inflammatory disorders, causing dermatitis due to skin rubbing on eyeglass lenses.

B. Documentation in the medical records indicates **all of the following**:
   1. A frontal, straight-ahead photograph showing the condition, and/or side photographs
   2. Diagnosis and description of functional impairment that relates to the need for blepharoplasty.

Note: For members with unilateral disease meeting criteria for the above-listed procedures, surgery of the contralateral eye may be considered medically necessary to obtain symmetry.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx

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