

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Blepharoplasty	1
1.2	Brow Lift.....	1
1.3	Medical Term Definitions.....	1
2.0	Eligible Recipients	2
2.1	General Provisions	2
3.0	When the Procedure, Product, or Service Is Covered.....	2
3.1	General Criteria.....	2
3.2	Specific Criteria	2
4.0	When the Procedure, Product, or Service Is Not Covered.....	5
4.1	General Criteria.....	5
4.2	Specific Criteria	5
5.0	Requirements for and Limitations on Coverage	5
5.1	Prior Approval	5
6.0	Providers Eligible to Bill for the Procedure, Product, or Service	5
7.0	Additional Requirements	6
7.1	Compliance	6
8.0	Policy Implementation/Revision Information.....	6
	Attachment A: Claims-Related Information	7
A.	Claim Type	7
B.	Diagnosis Codes	7
C.	Procedure Code(s).....	7
D.	Modifiers.....	7
E.	Billing Units.....	7
F.	Place of Service	7
G.	Co-payments	7
H.	Reimbursement	7

1.0 Description of the Procedure, Product, or Service

The goal of functional or reconstructive eyelid surgery is to improve abnormal function, reconstruct deformities, repair defects due to trauma or tumor-ablative surgery and in general to restore normalcy to the eyelid. Eyelid surgery may be performed for either functional/reconstructive or cosmetic purposes.

Brow ptosis refers to the sagging tissue of the eyebrows and/or forehead. In extreme cases brow ptosis can obstruct the field of vision causing a functional impairment. Brow ptosis is caused by aging changes in the forehead muscle and skin, which leads to weakening of these tissues and sagging of the eyebrows. Brow lift is a surgical procedure that raises the eyebrows.

Note: This policy includes criteria specific to blepharoplasty and brow lift.

1.1 Blepharoplasty

Blepharoplasty is a surgical eyelid procedure that may be performed for functional, reconstructive or cosmetic purposes. Under this broad description, blepharoplasty includes procedures to repair ptosis, eyelid retraction, entropion, ectropion, trichiasis, or defects following excision of tumors. The most common functional indication for blepharoplasty is a superior visual field defect secondary to redundant upper eyelid tissue (dermatochalasis) that overhangs the eyelid margin and in common usage, the term "blepharoplasty" usually refers to the operation performed for dermatochalasis. However, for the purposes of this policy, the term blepharoplasty is used to indicate the broader description to include functional, reconstructive or cosmetic procedures.

Visual field testing is a measurement of all of the area a recipient can see while they are facing forward with their eyes fixed on an object in front of them. It includes the area straight ahead as well as the peripheral vision. Visual field impairment may result in the need for functional blepharoplasty. Generally, lower eyelid blepharoplasty is performed for cosmetic purposes; however, there are functional indications for the procedure.

1.2 Brow Lift

Brow Lift or "forehead lift" involves raising the eyebrow, forehead, and orbital region of the face. It often accompanies other plastic surgical procedures of the face, including cosmetic procedures of the eyelids, lower face and neck. It is generally performed to correct signs of aging (facial rejuvenation). Brow ptosis refers to sagging tissue of the eyebrows and/or forehead. In extreme, but rare cases, brow ptosis can obstruct the field of vision causing a functional impairment.

1.3 Medical Term Definitions

- a. Ablative: relating to or involving surgical ablation (surgical removal).
- b. Anophthalmic: congenital absence of the eyes.
- c. Blepharospasm: condition characterized by uncontrollable, forcible closure of the eyelids caused by a progressive dysfunction of the nerve that controls muscles around the eye. Less serious form may cause eyelid twitches or tics.

- d. Cosmetic: a procedure that is primarily intended to improve appearance, not restore bodily function.
- e. Epiphora; overflow of tears down the cheek caused by defective tear drainage system or by excessive flow of tears.
- f. Marginal reflex distance (MRD): the distance between the center of the pupillary light reflex and the upper eyelid margin with the eye in primary gaze. A measurement of greater than 2.5 mm is considered normal.
- g. Orbital region: the boney cavity containing the eyeball and its associated muscles, vessels and nerves.
- h. Peripheral: located near the periphery, not centralized.
- i. Plastic surgery: Surgery concerned with the restoration, reconstruction, correction, or improvement in the shape and appearance of body structures.
- j. Sequela: any lesion or affection following or caused by an attack of disease.
- k. Trichiasis: a condition of ingrowing hairs about an orifice, or of ingrowing eyelashes.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

For reconstructive eyelid surgery or brow lift surgery to be covered under the NC Health choice Program, the purpose of the surgery must be to restore vision.

- a. Reconstructive Eyelid Surgery, specifically Blepharoplasty, is covered under the NC Health Choice Program when it is determined to be medically necessary because the following medical criteria are met.

1. Blepharoplasty procedures of the upper eyelid may be considered medically necessary for any of the following indications:
 - (a) Clinically significant impairment of upper/outer visual fields (<30 degrees from fixation) by excessive upper eyelid skin (dermatochalasis). Visual fields must be extended by at least 15 degrees by raising the redundant upper eyelid tissue, as documented by either a Goldmann Perimeter or a programmable automated testing method. Photographs must be submitted and should be consistent with the degree of visual field impairment described in the medical records and demonstrated by the formal visual field testing.
 - (b) The upper eyelid position contributes to difficulty tolerating a prosthesis in an anophthalmic socket.
 - (c) To correct defects causing corneal or conjunctival irritation:
 - i. entropion - (eyelid turned inward);
 - ii. pseudotrichiasis - (inward misdirection of eyelashes caused by entropion);
 - iii. ectropion - (eyelid turned outward); or
 - iv. corneal exposure.
 - (d) To treat periorbital sequelae of thyroid disease and nerve palsy.
 - (e) To relieve painful symptoms related to blepharospasm or to relieve visual symptoms of debilitating blepharospasm.
 - (f) Ptosis (blepharoptosis) repair for laxity of the muscles of the upper eyelid causing functional impairment. Records must document 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 (marginal reflex distance or MRD). Photographs must be submitted and should be consistent with the degree of visual field impairment described in the medical records and demonstrated by the MRD measurements.
 - (g) To repair defects caused by trauma or tumor-ablative surgery.
 - (h) To relieve chronic symptomatic dermatitis of pretarsal skin caused by redundant upper eyelid skin which has not been successfully treated by normal first line measures such as education regarding hygiene, antibiotics, etc. Documentation must include a description of onset, prior treatment, extent, presence and description of discharge, color, etc.
2. Blepharoplasty of the lower eyelid is generally considered cosmetic; however, lower eyelid blepharoplasty may be considered medically necessary for the following indications:
 - (a) Facial nerve damage with inability to close eye due to lower lid dysfunction;
 - (b) Corneal and/or conjunctival injury or disease due to ectropion, entropion or trichiasis;
 - (c) Following tumor ablative surgery;

- (d) Epiphora due to ectropion and/or punctal eversion.
- 3. Blepharoplasty documentation must include information relevant to the surgery proposed or performed including:
 - (a) Office records that indicate signs and symptoms of vision disturbance secondary to redundant or drooping upper eyelid tissue, including evaluation for Horner's syndrome. Recipient complaints may include interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin, etc. For entropion, pseudotrichiasis, ectropion, and corneal exposure specific symptoms, duration and severity must be noted. (Required for all cases).
 - (b) Degree and description of visual impairment and MRD. (Required for upper eyelid ptosis surgery.)
 - (c) Results from either a Goldmann Perimeter or a programmable automated perimeter visual field testing method. (Required for dermatochalasis surgery.)
 - (d) Photodocumentation (prints, not slides) as indicated below:
 - i. Frontal photographs, canthus to canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash or position of the true lid margin or the pseudo-lid margin.
 - ii. Close up lateral photographs with eyes open, upgaze and eyes closed.
 - iii. If redundant skin coexists with true lid ptosis, additional photos must be taken with the upper lid skin retracted to show the actual position of the true lid margin.
 - iv. Frontal and oblique photos are required to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.
- b. Brow lift surgery is generally considered cosmetic. However, it may be covered under the NC Health Choice Program when it is determined to be medically necessary because the following medical criteria are met:
 - 1. For severe brow ptosis, **ALL** of the following criteria must be met:
 - (a) Office records that indicate signs and symptoms of vision disturbance secondary to redundant or drooping brow. Recipient complaints may include interference with vision or visual field, difficulty reading or performing activities of daily living due to upper brow drooping, interfering with vision;
 - (b) Clinically significant impairment of upper/outer visual fields (<30 degrees from fixation) by drooping brow. Visual fields must be extended by at least 15 degrees by raising the redundant brow tissue, as documented by either a Goldmann Perimeter or a programmable automated testing method;

- (c) It must be clearly documented that visual field impairment cannot be corrected by upper lid blepharoplasty alone as shown by standardized methods of visual field testing; **AND**
- (d) Photographs should show the eyebrow below the supraorbital rim. Photographs before and after taping should show the functional effect of the proposed surgery. Lateral photographs must document the degree of hooding and relationship of brow to supraorbital rim.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

- a. Blepharoplasty is not covered by the NC Health Choice Program when performed primarily to improve appearance.
 - 1. When the medical necessity criteria in **Subsection 3.2** are not met, blepharoplasty is considered cosmetic and excluded from coverage.
 - 2. Lower lid blepharoplasty is generally considered cosmetic, except as noted in **Subsection 3.2.a.2**.
- b. Brow lift surgery is non-covered by the NC Health Choice Program when performed primarily to improve appearance. In the absence of documentation of medical necessity, it is considered cosmetic and excluded from coverage."

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is required for reconstructive eyelid surgery and brow lift surgery.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Codes				
15820	15821	15822	15823	67900
67901	67902	67903	67904	67906
67908	67909	67911	67914	67916
67917	67921	67923	67924	

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital and Office

G. Co-payments

Co-payment(s) may apply to covered prescriptions and services.

H. Reimbursement

Providers must bill their usual and customary charges.