Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Acquired Ptosis:

Aetna considers any of the following procedures medically necessary when the criteria described below are met:

I. Blepharoplasty is considered medically necessary for any of the following indications:

A. To correct prosthesis difficulties in an anophthalmia socket; or

B. To remove excess tissue of the upper eyelid causing functional visual impairment when the following criteria are met:

1. Photographs in straight gaze show

   a. Redundant eyelid tissue overhanging the upper eyelid margin or resting on or pushing down on the eye lashes; or

   b. The eyelid at or below the upper edge of the pupil

   (Note: Excess tissue beneath the eye rarely
obstructs vision, so the lower lid blepharoplasty is rarely covered for this indication); and

2. Documentation of a visual field test without the eyelid or brow taped, showing points of visual loss inside the twenty-five degree circle of the superior field, that is corrected when taped and shows improvement in the superior field with no visual loss inside the forty-degree circle of the superior field; or

C. To repair defects predisposing to corneal or conjunctival irritation:

- Corneal exposure
- Ectropion (eyelid turned outward)
- Entropion (eyelid turned inward)
- Pseudotrichiasis (inward misdirection of eyelashes caused by entropion); or

D. To relieve painful symptoms of blepharospasm; or
E. To treat peri-orbital sequelae of thyroid disease and nerve palsy, and peri-orbital sequelae of other nerve palsy (e.g., the oculomotor nerve); or
F. Lower lid blepharoplasty to relieve excessive lower lid bulk only if proper positioning of prescription eyeglasses is precluded and is secondary to conditions such as: chronic systemic corticosteroid therapy, dermatomyositis, Graves’ disease, myxedema, nephrotic syndrome, polymyositis, scleroderma, Sjögren’s syndrome, or systemic lupus erythematosus

II. Ptosis (blepharoptosis) repair for laxity of the muscles of the upper eyelid causing functional visual impairment when the following criteria are met:
A. Documentation of a visual field test without the eyelid or brow taped showing points of visual loss inside the 25-degree circle of the superior field, that is corrected when taped and shows improvement in the superior field with no visual loss inside the 40-degree circle of the superior field; and
B. Photographs in straight gaze show the margin reflex difference (distance from the upper lid margin to the reflected corneal light reflex at normal gaze) of 2 mm or less with the eyes in a straight gaze; and
C. Photographs of the individual looking straight ahead demonstrating:
   1. The eyelid at or below the upper edge of the pupil; or
   2. Redundant eyelid tissue overhanging the upper eyelid margin and/or resting on the eyelashes.

III. Brow ptosis repair for laxity of the forehead muscles causing functional visual impairment when the following criteria are met:

A. Photographs show the eyebrow below the supra-orbital rim; and
B. Documentation of a visual field test without the brow taped, shows points of visual loss inside the 25-degree circle of the superior field that is corrected when taped, and shows improvement in the superior field with no visual loss inside the 40-degree circle of the superior field; and
C. Brow ptosis is causing a functional impairment of upper/outer visual fields with documented interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin.

IV. Eyelid ectropion or entropion repair is considered medically necessary for corneal or conjunctival injury due to ectropion,
entropion or trichiasis.

V. Upper eyelid tightening procedures (block resection or tarsal strip with lateral canthal tightening) for member who has refractory corneal or conjunctival inflammation related to exposure from floppy eyelid syndrome.

VI. Canthoplasty is considered medically necessary for the following indications:

A. 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, or for a medically necessary blepharoplasty to correct entropion or ectropion; or

B. For reconstruction of the eyelid following resection of benign or malignant lesions involving the medial or lateral canthus.

Note:

Where medical necessity criteria indicate need for photographs, photos must be taken with the eyes not dilated or squinting. Photos are to be taken at eye level and depicting a frontal view. Photos must be of sufficient quality to show the light reflex on the cornea, and demonstrate the lid margins in relation to the pupil.

Excess upper eyelid skin, upper eyelid ptosis, or brow ptosis can be present alone or in any combination, and each may require correction. If both a blepharoplasty and ptosis repair are requested, 2 photographs may be necessary to demonstrate the need for both procedures: 1 photograph should show the excess skin above the eye resting on the eyelashes, and a 2nd photograph should show persistence of lid lag, with the upper eyelid crossing or slightly above the pupil margin, despite lifting the excess skin above the eye off of the eyelids with tape. If all 3 procedures (i.e., blepharoplasty, blepharoptosis repair, and brow ptosis repair) are requested, 3 photographs may be necessary.
Congenital Ptosis:

Aetna considers surgical correction of congenital ptosis medically necessary to allow proper visual development in infants and children when the following criteria are met

I. Infant or child has congenital ptosis (present at birth and detected within the first year of life); and
II. Ptosis interferes with field of vision (visual field testing not required); and
III. Child has abnormal head posture (e.g., head tilt or turn, chin up or chin down), amblyopia or strabismus.

Surgery is considered cosmetic if performed for mild ptosis that is only of cosmetic concern.

Periorbital Microcystic Lymphatic Malformation with Blepharoptosis:

Aetna considers intralesional bleomycin injection experimental and investigational for the treatment of periorbital microcystic lymphatic malformation with blepharoptosis because its effectiveness has not been established.

See also CPB 0031 - Cosmetic Surgery (0031.html).

Background

Blepharoplasty refers to surgery to remove excess skin and fatty tissue around the eyes. Blepharochalasis is a term used to refer to loose or baggy skin (dermatochalasis) above the eyes, so that a fold of skin hangs down, often concealing the tarsal margin when the eye is open. In severe cases, excess skin and fat above the eyes can sit on the upper eyelid and may obstruct the superior field of vision. Blepharochalasis may cause pseudoptosis (false ptosis), where the patient has a normal ability to elevate the eyelid, but bagging skin above the eye overhangs the eyelid margin, resembling ptosis. In some cases, excess skin around the eye may cause the eyelashes to turn in and to irritate the eye, or turn outward, resulting in exposure
Surgical removal of these overhanging skin folds may improve the function of the upper eyelid and restore peripheral vision. Blepharoplasty is also performed for cosmetic reasons to improve a sagging, tired appearance, and is the second most common aesthetic procedure performed by plastic surgeons. For coverage of this procedure, photographs in straight gaze should show sagging tissue above the eyes that is resting on or pushing down on the eyelashes.

Blepharoplasty to remove excess tissue either above or below the eyes may also be medically necessary and covered to correct prosthesis difficulties in an anophthalmia socket, to repair defects caused by trauma or tumor-ablative surgery, to correct an entropion (inward turned eyelid) or ectropion (outward turned eyelid), to treat peri-orbital sequelae of thyroid disease and nerve palsy, and to relieve painful blepharospasm.

Ptosis (also called blepharoptosis) is the term for drooping of one or both upper eyelids. This may occur in varying degrees from slight drooping to complete closure of the involved eyelid. In the most severe cases, the drooping can obstruct the visual field and cause positional head changes.

There are 2 types of ptosis: (i) acquired and (ii) congenital. Acquired ptosis is more common. Congenital ptosis is present at birth. Ptosis may occur because the levator muscle’s attachment to the lid is weakening with age. Acquired ptosis can also be caused by a number of different things, such as disease that impairs the nerves, diabetes, injury, tumors, inflammation, or aneurysms. Congenital ptosis may be caused by a problem with nerve innervation or a weak muscle. Drooping eyelids may also be the result of diseases such as myotonic dystrophy or myasthenia gravis.

The primary symptom of ptosis is a drooping eyelid. Adults will notice a loss of visual field because the upper portion of the eye
is covered. Children who are born with a ptosis usually tilt their head back in an effort to see under the obstruction. Some people raise their eyebrows in order to lift the lid slightly and therefore may appear to be frowning.

Diagnosis of ptosis is usually made by observing the drooping eyelid. Ptosis is usually treated surgically. Surgery can generally be done on an outpatient basis under local anesthetic. For minor drooping, a small amount of the eyelid tissue can be removed. For more pronounced ptosis the approach is to surgically shorten the levator muscle or connect the lid to the muscles of the eyebrow. Or, the aponeurosis can be re-attached to the tarsal plate if it had separated. Correcting the ptosis is usually done only after determining the cause of the condition.

Ptosis (blepharoptosis) repair for laxity of the muscles of the upper eyelid causing functional visual impairment is covered when photographs in straight gaze show the eyelid margin across the midline or at the most 1 or 2 mm above the midline of the pupil (see Figure).

**Figure:** Diagram of upper lid margin crossing the pupil

To demonstrate the medical necessity of both blepharoplasty and ptosis (blepharoptosis) repair, 2 sets of photographs may be needed. One set of photographs (front and side views) should demonstrate the excess skin above the eyes resting on the eyelashes. A second set of photographs should be taken with the excess skin lifted off of the eyelashes (such as by taping the excess skin to the forehead), and demonstrating persistence of ptosis with the lid margin across the midline of the pupil or 1 to 2 mm above the pupil midline.
Brow ptosis refers to sagging tissue of the eyebrows and/or forehead. In extreme cases, brow ptosis can obstruct the field of vision. 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 ptosis is treated surgically with the specific operation being based on the amount and location of the brow ptosis.

Brow ptosis surgery is usually performed under local anesthesia as an outpatient procedure. Excess skin and muscle is excised and the deep tissues are sutured together. Brow ptosis repair for laxity of the forehead muscles causing functional visual impairment is covered when photographs show the eyebrow below the supra-orbital rim.

Often brow ptosis coexists with eyelid ptosis and dermatochalasis; in these cases, ptosis surgery and blepharoplasty may be performed at the time of the brow ptosis surgery. The medical necessity of each surgical procedure may need to be demonstrated with separate photographs: 1 photograph should show the eyebrow below the supra-orbital rim, a 2nd photograph with the sagging forehead lifted up in order to see the sagging tissue above the eye resting on the eyelashes, and then a 3rd with the sagging tissue lifted off of the eyelid in order to see the persistent lid lag (ptosis).

Canthoplasty, also known as inferior retinacular suspension or lateral retinacular suspension, involves tightening the muscles or ligaments that provide support to the outer corner of the eyelid. This procedure may be medically necessary where drooping of the outer corner of the eyelid interferes with vision.

Visual field testing measures the entire scope of vision by creating an individual "map" of each eye. With one eye covered, the individual responds to light and/or various intensities of movement by pushing a button, allowing the computer to generate a map of the visual fields. Testing may be completely automated or performed by a technician with or
without the assistance of a machine. Testing the central 24 degrees or 30 percent of the visual field is most commonly used.

Visual field testing alone is not sufficient to determine the presence of excess upper eyelid skin, upper eyelid ptosis, or brow ptosis. A patient could cause a visual field defect by lowering their lids during the test. Photographs that document eyelids crossing the pupils provide additional support for the need of surgery.

If visual field tests are performed, the tests should show loss of 2/3 or greater of a visual field in the upper or temporal areas documented by computerized visual field studies, with visual field restored by taping or holding up the upper lid.

An UpToDate review on ptosis (Lee, 2013) states that “In patients with third nerve [oculomotor nerve] palsy, an interval of 6 to 12 months before surgical intervention is advised because many will have spontaneous recovery. Similarly, patients with MG [myasthenia gravis] should have stable disabling ptosis for several months on maximal medical therapy before considering surgical therapy”.

**Intralesional Bleomycin Injection:**

Yang et al (2015) stated that peri-orbital microcystic lymphatic malformations (LM) can cause severe symptoms, such as blepharoptosis, amblyopia, chemosis, strabismus, diminished vision, and blindness. In a retrospective study, these researchers evaluated the clinical outcome in peri-orbital microcystic LM patients with blepharoptosis who underwent surgical treatment combined with intralesional bleomycin injection. A total of 9 patients diagnosed as peri-orbital microcystic LM with blepharoptosis were included in this study. All of them underwent surgical treatment and bleomycin injection from January 2010 to January 2014. The lesion was resected through the lower eyebrow and/or a coronal incision at the first stage, and levator resection was performed at the
second stage. Any persistent lesion or its recurrence was managed by intralesional bleomycin injection. Blepharoptosis and visual obstruction were corrected in all patients. Mean follow-up was 24.6 months; 6 patients had recurrence during follow-up; and 2 patients who had partial eyelid closure after the second stage surgery recovered in 3 months. Amblyopia, astigmatism, and strabismus were not improved after treatment. All patients had excellent aesthetic improvement and corrected blepharoptosis. The authors concluded that resection through a lower eyebrow and coronal incision and levator resection performed in 2 stages can quickly correct the visual impairment caused by peri-orbital microcystic LM with blepharoptosis. They stated that intralesional bleomycin injection is a promising adjunctive therapy for residual or recurrent lesions after surgery.

<table>
<thead>
<tr>
<th>CPT Codes / HCPCS Codes / ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by &quot;+&quot;:</td>
</tr>
<tr>
<td><strong>Blepharoplasty:</strong></td>
</tr>
<tr>
<td><strong>CPT codes covered if selection criteria are met:</strong></td>
</tr>
<tr>
<td>15820</td>
</tr>
<tr>
<td>15821 with extensive herniated fat pad [excess tissue beneath the eye rarely obstructs vision so lower lid blepharoplasty is rarely covered for this indication]</td>
</tr>
<tr>
<td>15822</td>
</tr>
<tr>
<td>15823 with excessive skin weighing down lid</td>
</tr>
<tr>
<td>67950</td>
</tr>
<tr>
<td><strong>ICD-10 codes covered if selection criteria are met:</strong></td>
</tr>
<tr>
<td>H02.001 - H02.059</td>
</tr>
<tr>
<td>H04.201 - H04.219</td>
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<tr>
<td>H05.89</td>
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</table>
### Ptosis repair:

#### CPT codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)</td>
</tr>
<tr>
<td>67902</td>
<td>Frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67903</td>
<td>(Tarso) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>(Tarso) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>Superior rectus technique with fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67908</td>
<td>Conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)</td>
</tr>
<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
</tr>
</tbody>
</table>

#### Other CPT codes related to the CPB:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11900</td>
<td>Injection, intralesional</td>
</tr>
<tr>
<td>11901</td>
<td></td>
</tr>
<tr>
<td>92081</td>
<td>Visual field examination [not routinely necessary for excess upper eyelid skin, upper eyelid ptosis, or brow ptosis]</td>
</tr>
<tr>
<td>92083</td>
<td></td>
</tr>
</tbody>
</table>

#### ICD-10 codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H02.401</td>
<td>Ptosis of eyelid [causing functional visual impairment]</td>
</tr>
<tr>
<td>H02.439</td>
<td></td>
</tr>
<tr>
<td>Q10.0</td>
<td>Congenital ptosis [moderate to severe]</td>
</tr>
</tbody>
</table>

### Intralocular bleomycin injection:

#### HCPCS codes not covered for indications listed in the CPB:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9040</td>
<td>Injection, bleomycin sulfate, 15 units</td>
</tr>
</tbody>
</table>

#### ICD-10 codes not covered for indications listed in the CPB:
<table>
<thead>
<tr>
<th>I89.9</th>
<th>Other specified noninfective disorders of lymphatic vessels and lymph nodes [peri-orbital microcystic lymphatic malformation with blepharoptosis]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q15.8</td>
<td>Other specified congenital malformations of eye [peri-orbital microcystic lymphatic malformation with blepharoptosis]</td>
</tr>
</tbody>
</table>

**Ectropion or Entropion repair:**

**CPT codes covered if selection criteria are met:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67914</td>
<td>Repair of ectropion; suture</td>
</tr>
<tr>
<td>67915</td>
<td>thermocauterization</td>
</tr>
<tr>
<td>67916</td>
<td>excision tarsal wedge</td>
</tr>
<tr>
<td>67917</td>
<td>extensive (eg, tarsal strip operations)</td>
</tr>
<tr>
<td>67921</td>
<td>Repair of entropion; suture</td>
</tr>
<tr>
<td>67922</td>
<td>thermocauterization</td>
</tr>
<tr>
<td>67923</td>
<td>excision tarsal wedge</td>
</tr>
<tr>
<td>67924</td>
<td>extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)</td>
</tr>
</tbody>
</table>

**ICD-10 codes covered if selection criteria are met:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H02.001-H02.009</td>
<td>Entropion of eyelid</td>
</tr>
<tr>
<td>H02.101-H02.109</td>
<td>Ectropion of eyelid</td>
</tr>
<tr>
<td>Q10.1-Q10.3</td>
<td>Congenital ectropion, entropion and other congenital malformations of eyelids</td>
</tr>
</tbody>
</table>

**The above policy is based on the following references:**

3. Apfelberg DB. Summary of the 1997 ASAPS/ASPRS Laser
41. Lee MS. Overview of ptosis. UpToDate [online serial]. Waltham, MA: UpToDate; reviewed October 2013.
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Amendment to
Aetna Clinical Policy Bulletin Number: CPB 0084 Ptosis Surgery

There are no amendments for Medicaid.