Coverage of any medical intervention discussed in a WellFirst Health medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws.

**Blepharoplasty or Blepharoptosis (Eyelid Surgery)**

**MP9214**

**Covered Service:** Yes

**Prior Authorization Required:** Yes

**Additional Information:** None

**WellFirst Health Medical Policy:**

1.0 Upper eyelid blepharoplasty requires prior authorization through the Health Services Division and is considered medically necessary for ANY of the following indications:

   1.1 Dermatochalasis with upper visual field testing loss of at least 12 degrees or 24% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelid, and frontal photographs document medical necessity;

   1.2 To correct prosthesis difficulties in an anophthalmic socket;

   1.3 Painful blepharospasm that is refractory to medical management (e.g. botulinum toxin injections);

   1.4 Orbital sequelae of thyroid disease or nerve palsy (e.g. exposure keratitis);

   1.5 If one eye meets the above criteria, surgery may be appropriate on the other eye if there is significant superior visual field impairment approaching but not necessarily meeting the criteria above.

2.0 Lower lid blepharoplasty requires prior authorization through the Health Services Division and is considered medically necessary for the following:

   2.1 To relieve excessive lower lid bulk only if proper positioning of prescription eyeglasses is precluded and is secondary to conditions such as (e.g. chronic systemic corticosteroid therapy, dermatomyositis, Grave’s disease, myxedema, nephrotic syndrome, polymyositis, scleroderma, Sjogren’s syndrome, or systemic lupus erythematosus).

3.0 Upper eyelid ptosis repair for laxity of muscles of the upper eyelid requires prior authorization through the Health Services Division and is considered medically necessary when ANY of the following criteria are met:

   3.1 Congenital ptosis with amblyopia;

   3.2 Visual field testing shows superior visual field loss of 12 degrees of vision or 24% impairment;

   3.3 Margin reflex distance 1 (MRD₁) is ≤ 2.0 mm in central gaze;

   3.4 Margin reflex distance 1 (MRD₁) is ≤ 2.0 mm in down gaze with impairment of reading...
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4.0 Brow ptosis repair for laxity of forehead muscles causing functional visual impairment requires prior authorization through the Health Services Division and is considered medically necessary when the following criteria are met:

   4.1 There is redundant skin overhanging the supraorbital rim confirmed by photograph; AND

   4.2 Upper visual field loss of at least 12 degrees or 24% on visual field testing that cannot be corrected by upper lid blepharoplasty;

   4.3 If one eye meets the above criteria, surgery may be appropriate on the other eye if there is significant superior visual field impairment approaching but not necessarily meeting the criteria above.

5.0 Frontal photographs that document the medical necessity for any eyelid repair must be included with all prior authorization requests.

6.0 The following procedures do not require prior authorization and are considered medically necessary:

   6.1 Eyelid ectropion or entropion to repair defects predisposing to corneal and/or conjunctival injury or disease due to ectropion, entropion, or psuedotrichiasis.

   6.2 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

   6.3 Canthoplasty/canthopexy for ANY of the following indications:

      6.3.1 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;

      6.3.2 For reconstruction of the eyelid following resection of benign or malignant lesions involving the medial or lateral canthus;

      6.3.3 For management of exposure keratoconjunctivitis resulting from proptosis with lower lid retraction following orbital decompression surgery for Grave’s ophthalmopathy or Crouzon’s syndrome.

7.0 The following procedure is considered not medically necessary and therefore not covered:

   7.1 Upper eyelid repair performed for the sole purpose of improving the patient’s appearance (in the absence of any signs or symptoms of abnormality
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