Clinical Review Criteria

Blepharoplasty
- Blepharoptosis
- Brow Lift

NOTICE: Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited.

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Review Criteria, at Kaiser Permanente's sole discretion, at any time, with or without notice. Member contracts differ in their benefits. Always consult the patient's Medical Coverage Agreement or call Kaiser Permanente Customer Service to determine coverage for a specific medical service.

Criteria
For Medicare Members

<table>
<thead>
<tr>
<th>Source</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Coverage Manuals</td>
<td>None</td>
</tr>
<tr>
<td>National Coverage Determinations (NCD)</td>
<td>None</td>
</tr>
<tr>
<td>Local Coverage Determinations (LCD)</td>
<td>Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286) For cosmetic purposes See Non-Covered Services (L35008).</td>
</tr>
<tr>
<td>Local Coverage Article</td>
<td>None</td>
</tr>
</tbody>
</table>

For Non-Medicare Members

Blepharoplasty or brow ptosis repair will be considered medically necessary when ONE of the following are met:

I. **Blepharoplasty** is considered medically necessary and NOT cosmetic when ONE of the following is met:
   A. Blepharoplasty for the following diagnoses may be considered medically necessary for an affected upper or lower lid without meeting visual loss criteria:
      1. Trichiasis
      2. Ectropian
      3. Entropian
   B. In the absence of one of the conditions listed above unilateral or bilateral upper lid blepharoplasty or levator resection may be considered medically necessary for reconstructive purposes when the operative eye meets ALL of the following criteria:
      1. Visual field less than 20° above central fixation – (untaped eye) OR limited to 10 to 15 degrees (untaped eye) laterally
      2. MRD1 (marginal reflex distance from pupil center to upper eyelid) of 2 mm or less is required for the treatment of ptosis. Submission of MRD1 is not required for dermatochalasis
      3. Frontal or lateral photograph demonstrates visual field limitation consistent with the visual field examination, AND
      4. Does not have unstable myasthenia gravis or a thyroid condition
   5. **ALL of following** information must be submitted:
      - Visual fields, including physician interpretation
      - MRD1 (marginal reflex distance) measurement
      - Documentation of clinically decreased vision
      - Lateral and full face photographs

II. **Brow ptosis repair** may be considered medically necessary for reconstructive purposes when the operative eye meets ALL of the following criteria:
   A. Photographs demonstrate the eyebrow is below the super orbital rim
   B. Visual field less than 20° above central fixation
   C. MRD1 of 2 mm or less
   D. Frontal or lateral photograph demonstrates visual field limitation consistent with the visual field examination, AND
E. Does not have unstable myasthenia gravis or a thyroid condition

F. **ALL of following** information must be submitted:
   - Visual fields, including physician interpretation
   - MRD1 (marginal reflex distance) measurement
   - Documentation of clinically decreased vision
   - Lateral and full face photographs

III. **Blepharoplasty in anophthalmia** is considered medically necessary when
   A. The upper eyelid position interferes with the fit of eye prosthesis in the socket.

IV. Blepharoplasty of the lower lids for excessive skin that does not correct a functional issue is considered **cosmetic** under the member benefit.

If requesting this service, please send the following documentation to support medical necessity:
   - Visual fields, including physician interpretation
   - MRD1 (marginal reflex distance) measurement
   - Documentation of clinically decreased vision
   - Lateral and full face photographs

---

**Background**

This service is covered when it is medically indicated and determined not to be for cosmetic. The Medicare coverage language includes the identification of how to determine medical necessity. This is the language that has been adopted by Kaiser Permanente.

In order to determine coverage, the clinical history submitted by the requesting physician should include the reason for the surgery and the identification of the procedure to be done.

**Evidence and Source Documents**

**References:**
- Kaiser Permanente Coverage Contract Language
- Medicare Coverage Manual /PROW Criteria

Medicare Part B News 180, March 2000, topic 1143 entry #5782, applicable to Washington State. And effective in March 2000 as of publish date.

<table>
<thead>
<tr>
<th>Date Created</th>
<th>Date Reviewed</th>
<th>Date Last Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/30/1998</td>
<td>05/04/2010&lt;sup&gt;MDRCPC&lt;/sup&gt;, 03/01/2011&lt;sup&gt;MDRCPC&lt;/sup&gt;, 01/03/2012&lt;sup&gt;MDRCPC&lt;/sup&gt;, 11/06/2012&lt;sup&gt;MDRCPC&lt;/sup&gt;, 09/03/2013&lt;sup&gt;MPC&lt;/sup&gt;, 06/03/2014&lt;sup&gt;MPC&lt;/sup&gt;, 02/03/2015&lt;sup&gt;MPC&lt;/sup&gt;, 12/01/2015&lt;sup&gt;MPC&lt;/sup&gt;, 10/04/2016&lt;sup&gt;MPC&lt;/sup&gt;, 08/01/2017&lt;sup&gt;MPC&lt;/sup&gt;, 07/10/2018&lt;sup&gt;MPC&lt;/sup&gt;</td>
<td>10/04/2016</td>
</tr>
</tbody>
</table>

<sup>MDRCPC</sup> Medical Director Clinical Review and Policy Committee

<sup>MPC</sup> Medical Policy Committee

<table>
<thead>
<tr>
<th>Revision History</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/27/2015</td>
<td>Added new LCD L35536</td>
</tr>
<tr>
<td>09/08/2015</td>
<td>Revised LCD to L36281, L34886, L35008</td>
</tr>
<tr>
<td>10/04/2016</td>
<td>Added indication: OR limited to 10 to 15 degrees (untapped eye) laterally</td>
</tr>
</tbody>
</table>

**Codes**

Blepharoplasty – 15820, 15821, 15822, 15823
Brow Lift – 67900
Blepharoptosis – 67901, 67902, 67903, 67904, 67906, 67908, 67909

© 1998 Kaiser Foundation Health Plan of Washington. All Rights Reserved.