

Clinical Policy: Blepharoplasty, Ptosis Repair and Canthoplasty

Reference Number: CP.VP.07

Last Review Date: 08/2025

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Description

Upper eyelid blepharoplasties, ptosis repairs and canthoplasty procedures are utilized to alleviate obstruction of the visual field due to eyelid encroachment into the visual axis. This policy describes the medical necessity requirements for blepharoplasty ptosis repair and canthoplasty procedures.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® (Centene) and Envolve Vision, Inc.® (Envolve) that blepharoplasty, ptosis repair and canthoplasty procedures are **medically necessary** for the following indications:
 - A. Blepharoplasty, upper eyelid, or repair of brow ptosis, all of the following:
 1. Visual obstruction defined by peripheral visual field testing consistent with a minimum of 12 degrees or 30% loss of upper field of vision, as demonstrated on taped and untaped peripheral visual field testing and photos in primary gaze
 2. Patient complaints of visual impairment secondary to abnormal eyelid or brow position resulting in limitation of daily activities such as reading, driving, and difficulty seeing objects approaching from the periphery, or redundant upper eyelid skin resulting in looking through the eyelashes or seeing the upper eyelid skin.
 - B. Blepharoptosis repair: all of the following:
 1. Visual obstruction defined by peripheral visual field testing consistent with a minimum of 12 degrees or 30% loss of upper field of vision, as demonstrated on taped and untaped peripheral visual field testing and photos in primary gaze
 2. Patient complaints of visual impairment secondary to abnormal eyelid or brow position resulting in limitation of daily activities such as reading, driving, and difficulty seeing objects approaching from the periphery, or redundant upper eyelid skin resulting in looking through the eyelashes or seeing the upper eyelid skin.
 3. Marginal reflex distance (MRD) of 2mm or less with gaze in primary position.
 - C. Canthoplasty (reconstruction of canthus), all of the following:
 1. As part of a blepharoplasty procedure to correct eyelids that sag to the extent that they pull down the upper eyelid causing visual field obstruction.
- II. It is the policy of health plans affiliated with Centene and Envolve that lower eyelid blepharoplasties are cosmetic and considered **not medically necessary**.

Background

Upper eyelid blepharoplasty is a surgical procedure performed to remove redundant upper eyelid skin and/or excessive fat in patients with dermatochalasis. Patients who are candidates for blepharoplasty are patients whose dermatochalasis causes interference with vision or visual field, related to daily activities such as, difficulty reading, driving, watching television, or using a computer due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue. Patients might describe the need to manually elevate their eyelid to see

and also might experience a brow ache or headache from constant brow elevation, adopt a compensatory chin elevation, or bump their head on overhead objects.

Patients with ptosis or dermatochalasis may also complain of seeing their own lashes or feeling them irritating their cornea. Elevation of the lid via neosynephrine does not substantially improve these patients, as the skin remains redundant and overhanging. Patients who have normal lid margin position but severe dermatochalasis are candidates for blepharoplasty alone. Patients who undergo upper lid ptosis are not automatically candidates for simultaneous blepharoplasty simply because a small amount of skin is removed as part of the procedure.

Repair of brow ptosis may be considered medically necessary when documentation demonstrates brow ptosis to the extent it contributes to skin fold overlap and/or blepharoptosis meeting the criteria outlined below for upper eyelid blepharoplasty and/or ptosis surgery. Blepharoptosis (ptosis) repair is a surgical procedure performed to elevate the upper eyelid margin in patients with congenital or acquired ptosis and can be accomplished by procedures such as external levator resection or advancement, posterior approach Muller's muscle and conjunctival resection, or frontalis suspension.

Canthoplasty is considered medically necessary as part of a blepharoplasty procedure to correct eyelids that sag so much that they pull down the upper eyelid so that vision is obstructed.

Ptosis is a downward displacement of the upper eyelid margin due to congenital defect, inflammation, nerve disorder, traumatic deformity, myogenic, mechanical or age related degenerative changes of the eyelid and supporting structures. Dermatochalasis is excessive eyelid skin, usually the result of the aging process with loss of elasticity. Dermatochalasis may also result from specific disorders, such as thyroid eye disease, floppy eyelid syndrome, blepharochalasis syndrome, trauma, or any condition that causes stretching of the upper eyelid skin.

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.

Coding Implications

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CPT® Codes	Description
15820*	Blepharoplasty, lower eyelid
15821*	Blepharoplasty, lower eyelid; with extensive herniated fat pad

CPT® Codes	Description
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid with excessive skin weighing down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of Blepharoptosis; frontalis muscle technique with suture or other material (e.g. banked fascia)
67902	Repair of Blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of Blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of Blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle levator resection (e.g. Fasanella-Servat type)
67909	Repair of Blepharoptosis; conjunctivo-taro-Muller's muscle levator resection (e.g. Fasanella-Servat type)
67911	Correction of lid retraction
67950	Canthoplasty (reconstruction of canthus)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
H02.31	Blepharochalasis right upper eyelid
H02.34	Blepharochalasis left upper eyelid
H02.401	Unspecified ptosis of right eyelid
H02.402	Unspecified ptosis of left eyelid
H02.403	Unspecified ptosis of bilateral eyelids
H02.411	Mechanical ptosis of right eyelid
H02.412	Mechanical ptosis of left eyelid
H02.413	Mechanical ptosis of bilateral eyelids
H02.421	Myogenic ptosis of right eyelid
H02.422	Myogenic ptosis of left eyelid
H02.423	Myogenic ptosis of bilateral eyelids
H02.511	Blepharophimosis right upper eyelid
H02.512	Blepharophimosis right lower eyelid
H02.514	Blepharophimosis left upper eyelid
H02.515	Blepharophimosis left lower eyelid
H02.431	Paralytic ptosis of right eyelid
H02.432	Paralytic ptosis of left eyelid
H02.433	Paralytic ptosis of bilateral eyelids
H02.831	Dermatochalasis of right upper eyelid

ICD-10-CM Code	Description
H02.834	Dermatochalasis of left upper eyelid
H57.811	Brow ptosis, right
H57.812	Brow ptosis, left
H57.813	Brow ptosis, bilateral
Q10.0	Congenital ptosis
Q10.1	Congenital ectropion
Q10.2	Congenital entropion
Q10.3	Other congenital malformations of eyelid

Reviews, Revisions, and Approvals	Date	Approval Date
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Annual Review	11/2022	12/2022
Annual Review	11/2023	12/2023
Annual Review	11/2024	12/2024
Annual Review	08/2025	10/2025

References

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2. Kwitko GM, Patel BC. Blepharoplasty Ptosis Surgery. 2020 Sep 6. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. PMID: 29493921.
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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <https://www.cms.gov> for additional information.

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