

## Corporate Medical Policy

### Reconstructive Eyelid Surgeries

#### Description of Procedure or Service

Blepharoplasty and blepharoptosis repair are surgical procedures, which are performed to correct a drooping upper or lower eyelid many times caused by excess tissue that interferes with the normal visual field. The measurement most involved in the decision for blepharoplasty is the degree of loss in the nasal/superior measurement. A blepharoplasty is most commonly performed due to dermatochalasis (excessive skin of the eyelid). A blepharoplasty may also be indicated in cases of trauma to the eyelids and orbit.

Ectropion and entropion repair are performed for malpositions of the eyelid. Ectropion is eversion and downward pull of the lower eyelid away from the globe where it usually rests. Entropion is the turning in of the upper or lower margin of the eyelid. The most common type is senile or spastic entropion. Trichiasis is defined as the condition in which the lashes are turned inward against the cornea. It is associated with entropion.

Brow ptosis repair is performed because of age-related change caused by redundancy of forehead skin creating obstruction of the vision and lash ptosis. Brow ptosis may cause visual impairment. Brow lift involves raising the eyebrows

#### Background

Blepharoplasty is a procedure that reconstructs eyelid deformities, improves abnormal function and/or enhances appearance of the eyelids. Cosmetic blepharoplasty can improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities. Reconstructive blepharoplasty can restore function by transforming abnormal eyelid structures to a more normal state.

Dermatochalasis is defined as excess skin of the eyelids. It is characterized by deficient elastic fibers of the skin, which may hang in folds. Skin redundancy and/or muscle laxity involving the eyelids can impair vision.

These findings may cause pseudoptosis 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 keratitis.

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 lid. Blepharoplasty may also be used to remove excess tissue either above or below the eyes or to correct prosthesis difficulties in an anophthalmic 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 periorbital sequelae of thyroid disease and nerve palsy, and to relieve painful blepharospasm.

Ptosis occurs when the eyelid droops more than is considered normal, potentially impairing vision. Ptosis is usually categorized as either “true ptosis,” an intrinsic disturbance of the eyelid structures, or as a “pseudoptosis,” a lack of normal eyelid support or the presence of excess lid tissue that “hoods” the eye, restricting the upward gaze and blocking the peripheral and/or forward vision.

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. 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 reattached to the tarsal plate if it had separated. Correcting the ptosis is usually done only after determining the precipitating cause of the condition

Brow ptosis surgery can be performed under local or general anesthesia as an outpatient procedure. Numerous options in brow lifting exist that can be broadly categorized as open and minimally invasive or endoscopic. It is generally considered cosmetic but occasionally can be a functional procedure if visual impairment due to the brows is severe. A brow ptosis repair for laxity of the forehead muscles causing functional visual impairment is indicated when the eyebrow falls below the supra-orbital rim. And often brow ptosis coexists with eyelid ptosis and/or dermatochalasis; in these cases, ptosis surgery and blepharoplasty may be performed at the time of the brow ptosis surgery. (See Policy Guidelines)

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

### **Benefit Application**

Cosmetic surgery is not covered under the GEHA Benefit Plan and is defined as any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury if repair is initiated promptly or as soon as the member’s medical condition permits.

Blepharoplasty performed as a part of transgender procedures is not a covered benefit under the GEHA Benefit Plan in the absence of the medical necessity criteria herein defined being demonstrated.

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits.

## **Policy Statement**

GEHA will provide coverage for reconstructive eyelid surgeries when determined to be medically necessary because the medical criteria and guidelines as documented below have been demonstrated.

### **When Reconstructive Eyelid Surgeries are covered**

Blepharoplasty of the upper eyelids is considered medically necessary for any of the following indications:

- o To correct prosthesis difficulties in an anophthalmic socket; or
- o To remove excess tissue of the upper eyelid causing functional visual impairment when the following criteria are met:
  - documented superior visual field constriction to less than 25 degrees where visual fields will be extended by at least 15 degrees by raising the redundant upper eyelid tissue; AND
  - Color 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: AND
  - Redundant eyelid tissue overhanging the upper eyelid margin or resting on or pushing down on the eye lashes;
- o To repair defects causing significant corneal or conjunctival irritation (i.e. ectropion with evidence of corneal exposure such as exposure keratitis or corneal ulcer *or* entropion when local measures fail to control symptoms such as eye pain or corneal abrasion); objective findings must be demonstrated in the medical records submitted:
  - Ectropion (eyelid turned outward) present in color photos
  - Entropion (eyelid turned inward) present in color photos
  - Pseudotrachiasis (inward direction of eyelashes due to entropion) present in color photos; or
- o To relieve painful symptoms related to blepharospasm or to relieve visual symptoms of debilitating blepharospasm; or
- o To repair defects caused by trauma or tumor-ablative surgery; or
- o To treat peri-orbital sequelae of thyroid disease and nerve palsy, and peri-orbital sequelae of other nerve palsy (such as Bell's palsy).

Blepharoplasty of the lower eyelid is generally considered cosmetic; however, lower eyelid blepharoplasty may be considered medically necessary for the following indications:

- Facial nerve damage with inability to close eye due to lower lid dysfunction;
- Corneal and/or conjunctival injury or disease due to ectropion, entropion or trichiasis;
- Following tumor ablative surgery;
- Epiphora due to ectropion and/or punctal eversion.

o Ptosis (blepharoptosis) repair for laxity of the muscles of the upper eyelid causing functional visual impairment may be considered medically necessary when the following criteria are met:

o Documented superior visual field constriction to less than 25 degrees where visual fields will be extended by at least 15 degrees by raising the redundant upper eyelid tissue; and

o Demonstration of a marginal reflex difference or MRD (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

o Color photographs of the individual looking straight ahead demonstrating the eyelid at or below the upper edge of the pupil; and

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

o Photographs that show the eyebrows are 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; and

o Demonstrable evidence that the qualifying visual field disturbance would not be corrected by blepharoplasty alone as shown by standard methods of visual field testing, and;

o Documentation of a visual field test without the brow taped that shows points of visual loss inside the twenty-five degree circle of the superior field AND evidence that the visual field is corrected when the brow is taped and shows improvement in the superior field with no visual loss inside the forty degree circle of the superior field; and

o 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.

Canthoplasty may be covered as medically necessary when required as a part of an approved blepharoplasty procedure meeting any of the indications above or for reconstruction of the eyelid following resection of benign or malignant lesions involving the medial or lateral canthus.

*Note: For members with unilateral disease meeting criteria for the above-listed procedures, surgery of the contralateral eye may be considered medically necessary, in some circumstances, to obtain/maintain symmetry.*

#### **When Reconstructive Eyelid Surgeries are not covered**

A GEHA will not cover blepharoplasty, blepharoptosis repair or brow lift surgery when performed primarily to improve appearance. In the absence of documentation of medical necessity, these are considered cosmetic and excluded from coverage.

B Lower lid blepharoplasty is generally considered cosmetic, except as noted above.

## **Policy Guidelines**

Functional visual field deficits must be demonstrated and documented by either a Goldmann Perimeter or a programmable automated testing method.

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: 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).

## **Physician documentation**

Prior authorization for this service requires submission of all relevant medical record documentation, and at minimum must include the following:

- (1) Pre-operative ophthalmologic examination with visual field testing reports,
- (2) Evidence of functional deficits with documentation of tried and failed treatments,
- (3) Color photographs with front and side views,
- (4) Recent history and physical,
- (5) Letter of medical necessity

### **Scientific references**

American Society of Plastic Surgeons (ASPS). Practice Parameter for Blepharoplasty. Approved by the Executive Committee of the American Society of Plastic Surgeons®, March 2007.

MCG™ Care Guidelines, 21st edition, 2017. Blepharoplasty, Canthoplasty, and Related Procedures ACG: A-0195 (AC).

Trussler AP, Rohrich RJ. MOC-PSSM CME article: Blepharoplasty. *Plast Reconstr Surg*. 2008 Jan; 121 (1 Suppl): 1-10.

Orbit, Eyelids, and Lacrimal System, Section 7. Basic and Clinical Science Course. San Francisco: American Academy of Ophthalmology; 2009.

Burkat CN, Lemke BN. Acquired lax eyelid syndrome: an unrecognized cause of the chronically irritated eye. *Ophthal Plast Reconstr Surg*. 2005 Jan;21(1):52-8.

Fowler AM, Dutton JJ. Floppy eyelid syndrome as a subset of lax eyelid conditions: relationships and clinical relevance (an ASOPRS thesis). *Ophthal Plast Reconstr Surg*. 2010 May-Jun;26(3):195-204. doi: 10.1097/IOP.0b013e3181b9e37e.

Valenzuela AA, Sullivan TJ. Medial upper eyelid shortening to correct medial eyelid laxity in floppy eyelid syndrome: a new surgical approach. *Ophthal Plast Reconstr Surg*. 2005 Jul; 21(4):259-63.

Chambe J, Laib S, Hubbard J, et al. Floppy eyelid syndrome is associated with obstructive sleep apnoea: a prospective study on 127 patients. *J Sleep Res*. 2012 Jun;21(3):308-15.

Periman LM, Sires BS. Floppy eyelid syndrome: a modified surgical technique. *Ophthal Plast Reconstr Surg*. 2002 Sep;18(5):370-2.

### **Policy implementation and updates**

Dec 2017      Modification of criteria for covered procedures and guidance on additional indications. Policy renamed to appropriately identify the range covered services.

Dec 2018      Revised coverage criteria with clarity regarding covered and non-covered indications.