

**Blepharoplasty Upper Eyelid and Brow Surgical Procedures
Medicare Local Coverage Determination (LCD) - L34028 Checklist**

LCD-L34028	Patient Name:	MR:
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Effective Date: For services performed on or after 1/08/2019

Blepharoplasty is an upper eyelid and brow surgical procedure to repair droopy eyelids and/or eyebrows by removing excess of skin, muscle , or fat.

Effective 7/1/20: Blepharoplasty procedures require prior authorization - see the link for applicable CPT codes and regulation: [CMS Prior Authorization Initiative](#)

COVERAGE INDICATIONS

(A) Blepharoplasty is considered covered when performed as functional/reconstructive surgery to correct:	(B) Blepharoplasty procedures may be considered medically necessary when:	(C) Services Performed outside of the reasonable and necessary requirements in this LCD:
<ul style="list-style-type: none"> • Visual impairment with near or far vision due to dermatochalasis, blepharochalasis, or blepharoptosis, or brow ptosis, or • Visual impairment secondary to redundant skin weighting down on upper lashes, or • Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin which has not been successfully treated by normal first line measures such as education regarding hygiene, antibiotics, etc., or • Prosthesis difficulties in an anophthalmia socket., or • Interference with vision or the visual field, difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin as commonly seen with ptosis, pseudotosis or dermatochalasis. • Upper eyelid and brow surgical procedures may be considered medically necessary when the goal of the surgery is to restore functional and normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia, or developmental errors. 	<p>The goal of the surgery is to restore functional and normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia, or developmental errors.</p>	<p>Must use the redetermination process for consideration of services.</p>

LIMITATIONS

- Blepharoplasty procedures require prior authorization - to see the list of applicable CPT codes and regulation refer to this link.
<https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services>
- Blepharoplasty performed for the sole purpose of improving appearances is not covered. ABN may be provided to patients when services are not covered. When billing for non-covered services, use the appropriate modifier.

DOCUMENTATION REQUIREMENTS

Documentation meets the following requirements:

- Includes appropriate patient identification information and all maintained in the patient's medical record.
- Is legible including the signatures of the treating physician or non-physician practitioner.
- Supports the diagnosis (ICD-10-CM) codes and procedure/item (CPT/HCPCS) codes selected for billing.
- History and/or Physical include patient's complaint(s)-about their ability to see or function with their current level of vision, including the origin, extent and progression of the complaint; anatomic or physiological ocular problems and previous treatment.
- Includes an operative report
- Includes Visual Fields that meet the following requirements:
 - a) Recorded using either Goldmann Perimeter (III 4-E test object) or a programmable automated perimeter (equivalent to a screening field with a single intensity strategy using a 10 dB stimulus) to test a superior (vertical) extent of 50-60 degrees above fixation with targets presented at a minimum 4 degree vertical separation starting at 24 degrees above fixation while using no wider than a 10 degree horizontal separation.
 - b) Each eye is tested with the upper eyelid at rest and repeated with the lid elevated to demonstrate an expected "surgical" improvement meeting or exceeding the criteria.
 - c) Includes the Visual field interpretation demonstrating a minimum 12 degree or 30 percent loss of upper field of vision with upper skin and/or upper lid margin taped and untaped to demonstrate potential correction by the proposed procedure.
 - d) If patient is unable to perform visual field testing, documentation supports evidence of the medical condition which prevents the performance of the test, e.g., severe tremors, macular degeneration, physical deformities that prevent sitting up straight at the perimeter, and glaucoma.
- Includes photographs that meet the following requirements, when applicable:
 - a) Prints or slides are frontal, canthus to canthus with the head perpendicular to the plane of the camera (not tilted) to demonstrate a skin rash or position of the true lid margin or the pseudo-lid margin.
 - b) If redundant skin coexists with true lid ptosis, additional photos are taken with the upper lid skin retracted to show the actual position of the true lid margin (needed if both 15822-15823 is required and planned in addition to 67901-67908).
 - c) Oblique photos are only needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.
- For cases when both blepharoplasty and a ptosis repair are performed:
 - Supports and meets requirements for each procedure; One set of photographs and the visual fields may show both the effect of drooping of redundant skin (and its correction by taping), and the actual presence of blepharoptosis.

Note: If LCD criteria is not met, documentation must clearly outline the patient's episode of care that supports the procedure and must clearly address the reason(s) for coverage.

CODING INFORMATION

[For Coding Information view the Local Coverage Article for billing and coding guidelines: A57025 Upper Eyelid and Brow Surgical Procedures](#)

Checklist completed by: _____ Date: _____

Disclaimer: The content of the checklists were created as an educational tool. Use of these documents are not intended as a replacement for the documentation requirements published in National or Local Coverage Determinations, or the CMS's documentation guidelines, written law or regulations. Medicare policy changes frequently; Providers/Departments are reminded to review current National and Local Coverage Determination and Policy Articles for specific documentation and coding guidelines.