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MEDICAL POLICY – 7.01.508

Blepharoplasty, Blepharoptosis and Brow Ptosis Surgery

Effective Date:	Apr. 1, 2026	RELATED MEDICAL POLICIES:
Last Revised:	Mar. 10, 2026	10.01.514 Cosmetic and Reconstructive Services
Replaces:	N/A	

Select a hyperlink below to be redirected to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

There are usually two distinct reasons for eyelid surgery. The first is to change how a person looks. Surgery that only changes how a person looks is cosmetic surgery; the plan does not cover cosmetic surgery. The second reason for eyelid surgery is to fix a problem that causes medical issues or interferes with the ability to see. This policy discusses when eyelid surgery is covered.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Procedure	Medical Necessity
Upper eyelid blepharoplasty (15822, 15823)	**Upper eyelid blepharoplasty is considered medically necessary to relieve obstruction of central vision when ALL of the following criteria are met:** • Documented complaints of interference with vision or visual field-related activities causing significant functional visual

Procedure	Medical Necessity
	impairment (difficulty reading or driving due to upper eyelid skin drooping or resting or pushing down on the eyelashes) **AND** • There is excess skin overhanging the upper eyelid margin (edge of the eyelid) and resting on the eyelashes. This is confirmed by photographs from the front and side(s) with the camera at eye level and the individual looking straight ahead **AND** • Documentation of visual field testing with the eyelid skin untaped shows a superior or peripheral visual field of less than or equal to 20 degrees that is corrected to normal visual field limits when the excess upper eyelid skin is taped
Blepharoptosis repair (67901-67908)	**Blepharoptosis repair is considered medically necessary to relieve obstruction of central vision when ALL of the following criteria are met:** • Documented complaints of interference with vision or visual field-related activities causing significant functional visual impairment (difficulty reading or driving due to eyelid position) **AND** • Photographs taken with the camera at eye level and the individual looking straight ahead document the eyelid at or below the upper edge of the pupil **AND** • Documentation of visual field testing with the upper eyelid margin untaped shows a superior or peripheral visual field of less than or equal to 20 degrees that is corrected to normal visual field limits when the upper eyelid margin is taped **AND** • The margin reflex distance (MRD) between the pupillary light reflex at normal gaze and the upper eyelid skin edge is less than or equal to 2.0 mm
Brow lift (67900)	**Brow lift (repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when ALL of the following criteria are met:** • Brow ptosis is causing a functional visual impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as

Procedure	Medical Necessity
	difficulty reading due to upper brow drooping, looking through eyelashes, or seeing the upper eyelid skin **AND** • Photographs show the eyebrow below the supraorbital rim **AND** • Documentation of visual field testing with the brow untaped shows a superior or peripheral visual field of less than or equal to 20 degrees that is corrected to normal visual field limits when the eyebrow is taped
Children (9 years of age or younger)	**Blepharoptosis repair is considered medically necessary when BOTH of the following criteria are met:** • Individual is 9 years of age or younger* **AND** • Intervention is intended to relieve obstruction of central vision which is severe enough to produce occlusion amblyopia as documented by the treating physician **Note**: Children older than 9 years of age are not at risk for occlusion amblyopia
Lower eyelid blepharoplasty (CPT 15820, 15821)	**Lower eyelid blepharoplasty to remove excess skin, fatty tissue, or both, is considered cosmetic in the absence of the medical condition of ectropion, entropion, or other functional visual impairment. Excess tissue under the eye rarely obstructs vision.**
Canthoplasty/Canthopexy (21280, 21282, 67950)	**Canthoplasty/canthopexy may be considered medically necessary to correct any of the following reconstructive indications/functional impairments:** • Epiphora (excessive tearing) • Desiccation of the corneal epithelium (extreme dryness) • Corneal ulceration
Bilateral surgery	**When bilateral surgery is requested or performed and only one eye meets the medical necessity criteria noted above, surgery on the unaffected eye is considered cosmetic in the absence of signs or symptoms of a functional visual impairment.**
Surgery to improve appearance	**Blepharoplasty, blepharoptosis repair or brow lift not meeting the medical necessity criteria noted above is considered cosmetic in the absence of any significant signs or symptoms**

Procedure	Medical Necessity
	of a functional visual impairment and performed to improve an individual's appearance (see Related Policies).

Documentation Requirements

The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the relevant history and physical

AND

- Results of the visual field exam (when applicable)

AND

- Clear color photographs from the front and side(s) with the camera at eye level and the individual looking straight ahead (digital or film)

Additional documentation requirements for various conditions are detailed in the table below.

CPT Codes	Procedure Name	Indication	Additional Documentation Required
15820 15821	Lower eyelid blepharoplasty (See **Coding** section for individual code descriptions)	Lower eyelid ectropion, entropion, or trichiasis	Blepharoplasty of the lower eyelid is generally considered not medically necessary unless there is the presence of corneal and/or conjunctival injury or disease due to ectropion, entropion, Documentation should include the corneal exposure specific symptoms, duration, and severity
15822 15823	Blepharoplasty (See **Coding** section for individual code descriptions)	Excess skin (dermatochalasis, blepharochalasis)	Photographs from the front and side(s) with the camera at eye level and the individual looking straight ahead document excess skin overhanging the upper eyelid margin and resting on the eyelashes that are consistent with the visual field loss on visual field test results
67901 67902 67903 67904 67906 67908	Blepharoptosis (repair for laxity of the muscles of the upper eyelid) (See **Coding** section for individual code description)	Eyelid droop (Upper eyelid ptosis, blepharoptosis)	Photographs taken with the camera at eye level and the individual looking straight ahead document the eyelid at or below the upper edge of the pupil in addition to the MRD and the automated visual field test results

Documentation Requirements			
67900	Brow lift (repair of brow ptosis)	Laxity of the forehead muscles (brow ptosis)	Photographs show the eyebrow below the supraorbital rim in addition to the visual field test results

Coding

Code	Description
CPT	
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
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)
67950	Canthoplasty (reconstruction of canthus)

Related Information

Consideration of Age

The age described for when blepharoptosis repair may be considered medically necessary in children is 9 years old or younger. The surgery is done to prevent amblyopia. Based on feedback from a pediatric specialist, amblyopia generally does not occur after age 9.

Definition of Terms

When specific definitions are not present in a member's plan, the following definition of terms will be applied.

Brow ptosis: A condition where the eyebrow or forehead above the eye severely droops or sags down on to the eyelid. Individuals may have complaints of interference with vision or visual field, difficulty reading due to upper eyebrow drooping, upper eyelid sag, looking through the eyelashes or seeing the upper eyelid skin.

Blepharochalasis: Excess skin due to recurrent eyelid swelling (edema) that physically stretches the skin.

Blepharoptosis or ptosis: Abnormal relaxation of the muscles of the upper eyelid that causes eyelid skin to droop or sag and block the upper part of the visual field when the eye is looking straight ahead. It can affect one eye or both eyes and is more common in the elderly, as aging muscles in the eyelids may lose elasticity. However, one can be born with (congenital) ptosis.

Canthopexy: Is a minimally invasive surgical procedure that strengthens and tightens the lateral or medial corner of the eyelid using only sutures without cutting any tendons. The procedure is used to correct lower lid laxity. It is considered reconstructive when used to treat the functional impairments of epiphora, desiccation of the corneal epithelium, or corneal ulceration. It is considered cosmetic if used to improve an individual's appearance.

Canthoplasty: Is a surgical procedure that reshapes, tightens, and lifts the outer corner of the eye (lateral canthus) to treat sagging lower eyelids. It involves reconstruction of the muscles and tendons to reinforce the eye structure. It is considered reconstructive when used to treat the functional impairments of epiphora, desiccation of the corneal epithelium, or corneal ulceration. It is considered cosmetic if used to improve an individual's appearance.

Cosmetic: Services that are primarily intended to preserve or improve appearance. Cosmetic surgery is performed to reshape normal structures of the body in order to improve an individual's appearance or self-esteem.

Dermatochalasis: The presence of extra skin folds in the upper or lower eyelids due to the loss of elasticity and support causing lax eyelid skin. It can be a congenital or acquired medical condition; it is usually the result of the aging process. Blepharoplasty is the usual treatment to remove the eyelid skin and excess soft tissue.

Ectropion, lower eyelid: A medical condition where the lower eyelid margin has an abnormal eversion (outward turning) away from the globe. Without normal lid globe apposition, corneal exposure, tearing, keratinization of the palpebral conjunctiva and visual loss may result. Ectropion usually involves the lower lid and often has a component of horizontal lid laxity. There are several classifications of ectropion. Atonic ectropion follows paralysis of the orbicularis oculi muscle. Cicatricial ectropion of the eyelids occurs after burns, lacerations, or skin infection. Spastic entropion of the lower eyelid occurs as a result of ocular irritation.

Entropion, upper eyelid: A medical condition where the upper eyelid has an abnormal inversion (inward turning) of the eyelid margin. The primary conditions that occur are ocular surface irritation, corneal abrasions and scars. There are several classifications of entropion:

- Atonic entropion is a loss of tone of the orbicularis oculi muscle or elasticity of the skin.
- Cicatricial entropion is scarring of the palpebral conjunctiva.
- Spastic entropion arises from excessive contracture of the orbicularis oculi muscle.

Floppy eyelid syndrome: is a condition that affects the elasticity of the eyelids leading to sagging of the eyelids. It may be linked to the conditions of obesity, obstructive sleep apnea (OSA), and stomach/side sleepers. The lack of oxygen from OSA may increase the presence of enzymes that break down elastin which can lead to the sagging of the eyelids. This condition is more common in males and in older adults. This syndrome may lead to eye dryness, corneal irritation and/or inflammation, and photosensitivity. Surgery may be needed to tighten the eyelid tissue if the sagging eyelids are obstructing an individual's visual field.

Margin reflex distance (MRD): The distance between the upper eyelid margin and the mid-point of the pupil, with the eye in a straight-ahead gaze. Normal MRD is 4-5mm.

Physical functional impairment: A limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. Physical functional impairment can be due to

structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.

Reconstructive surgery: Surgeries performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function.

Benefit Application

Determinations of whether a proposed intervention would be considered reconstructive or cosmetic should always be interpreted in the context of the specific benefit language. State or federal mandates may also dictate coverage decisions.

Evidence Review

Description

Abnormalities of the eyelid that may indicate a need for surgery include excess eyelid skin, droopy eyelids, and eyelids that turn in or turn out. These problems can be unilateral or bilateral. These conditions can cause limited vision, discomfort, as well as affect appearance. Blepharoplasty is a surgical procedure performed on the upper and/or lower eyelids to remove or repair excess tissue, whether skin, fat, or both, that blocks the field of vision causing a functional limitation. The surgery may also be performed to correct entropion or ectropion. It may also be performed for cosmetic purposes in the absence of visual field obstruction.

Background

Clinically significant impairment of upper and outer visual fields may be caused by redundant or drooping skin of the upper lid and/or brow. The delicate skin of the eyelids may sag due to aging or heredity. A blepharoplasty is done for both functional and aesthetic reasons to surgically reduce or eliminate the sagging tissue of the eyelids. Functional reasons for surgery to restore impaired vision include ptosis, floppy eyelid syndrome, blepharochalasis, dermatochalasis, herniated orbital fat, and visual field obstruction.[1,2] Surgery may also include muscle repair or tightening to elevate ptotic eyebrows. Aesthetic reasons for surgery include a

desire for a more youthful, wide-eyed or less fatigued appearance. The surgery is usually done in an outpatient setting or ambulatory surgery center.

Blepharochalasis

Blepharochalasis is a rare degenerative disease unique to the skin of the eyelids. The disease is clinically characterized by primary bilateral swelling followed by progressive loss of subcutaneous tissue resulting in fine wrinkling and the skin of the upper lid hangs in thin folds. It is also termed ptosis atonia, ptosis adipose, and dermatolysispalpebrum. Blepharoplasty is the treatment of choice.[1]

Dermatochalasis

Upper eyelid dermatochalasis is the loss of elasticity and support in the skin. This condition presents as a fold of excess upper eyelid skin that can impair the job of the eye, including visual field obstruction. This can be either functional or cosmetic in nature. Aging can lead to a number of aesthetic changes in the lower eyelid including skin laxity or excess, orbital septum laxity, orbicularis laxity or hypertrophy, herniation of the orbital fat, canthal laxity, malar festoons, crow's feet, and periocular wrinkles[2]. Excess tissue under the eye rarely obstructs vision.

Ptosis (Blepharoptosis) – Congenital or Acquired

Ptosis is a drooping of the upper eyelid. It can block normal vision. Ptosis can be present in children or adults. Childhood ptosis can cause amblyopia or "lazy eye." Amblyopia is poor vision in an eye that does not develop normal sight during early childhood. Ptosis can be either congenital or acquired. Congenital ptosis is often caused by poor development of the levator muscle that lifts the eyelid. Although it is usually an isolated problem, a child born with ptosis may also have eye-movement abnormalities, muscular diseases, eyelid tumors or other tumors, neurological disorders, or refractive errors. Congenital ptosis usually does not improve with time. Early surgery is usually indicated for a droopy eyelid that blocks vision (which may cause delayed vision development) or causes a significant chin up head position (which may cause neck problems and/or delay of developmental skills).[3]

The most common cause of ptosis in adults is the separation or stretching of the levator muscle tendon from the eyelid. This process may occur as a result of aging, after cataract surgery or

other eye surgery, or as a result of an injury. Adult ptosis may also occur as a complication of other diseases involving the levator muscle or its nerve supply, such as neurological and muscular diseases (such as in myasthenia gravis) and, in rare cases, tumors of the eye socket.[4]

In 2011, Cahill et al. published a report from the American Academy of Ophthalmology (AAO) on the functional indications for upper eyelid surgery. Literature searches of the PubMed and Cochrane Library databases were conducted on July 24, 2008, with no age or date restrictions, except to limit the search to articles published in English. The goal of the literature review was to evaluate the functional indications and outcomes for blepharoplasty and blepharoptosis repair by assessing functional preoperative impairment and surgical results. Blepharoplasty surgery and ptosis surgery are different procedures performed to correct defects in different upper eyelid lamellae. Blepharoplasty is usually done to remove redundant soft eyelid tissue while blepharoptosis is a droopy eyelid due to causes other than redundant soft tissue (eg, abnormal muscle relaxation.) The researchers retrieved 1147 citations; 87 studies were reviewed in full text, and 13 studies met inclusion criteria and were included in the evidence analysis. The 13 studies reported the functional effects or treatment results of simulated ptosis; several types of blepharoptosis repair, including conjunctiva-Müller's muscle resection, frontalis suspension, and external levator resection; and upper eyelid blepharoplasty. Preoperative indicators of improvement included margin reflex distance 1 (MRD_1) of 2 mm or less, superior visual field loss of at least 12 degrees or 24%, down-gaze ptosis impairing reading and other close-work activities, a chin-up backward head tilt due to visual axis obscuration, symptoms of discomfort or eye strain due to droopy lids, central visual interference due to upper eyelid position, and patient self-reported functional impairment. However, the studies are small and the authors note that these studies are only Level III evidence. Additionally, the studies included in the review are primarily about the impact of surgical correction of ptosis, rather than on the identification of functional impairment.[5]

Transient Change in Eyelid Height After Unilateral Eyelid Surgery

Hering's law of equal innervation proposes that eyelid muscles are innervated equally by a single brainstem nucleus. Bilateral asymmetric ptosis may cause the less affected eye to appear normal due to compensation or by comparison to the more affected eye. Postoperatively, the ptosis in the untreated eye will be increased. Preoperatively, manual elevation of the more affected eyelid in an individual with unilateral ptosis may cause the higher eyelid to become ptotic (curtaining) indicating that bilateral surgical repair is needed. However, one report[6] indicates that this test may not be sensitive enough. Change in eyelid height of the non-surgical eyelid in unilateral ptosis surgery was studied in two small retrospective studies.

In 2004, Erb et al., evaluated the effect of unilateral blepharoptosis repair on contralateral eyelid position and assessed the relation between preoperative eyelid height interdependence, consistent with Hering law, and surgical outcome. The medical records of 54 patients (21 men, 33 women) with a mean age of 65 years were reviewed for pre- and post-operative MRD of the non-surgical eye, following external levator advancement for unilateral aponeurotic blepharoptosis. Using a 2-sample t-test the difference between preoperative Hering dependence (mechanical elevation of the ptotic eyelid causing a decrease in contralateral eyelid height) and postoperative eyelid position was assessed. The change in MRD of the non-surgical eye was compared between subjects who on preoperative evaluation did (n = 18) and did not (n = 36) have eyelid height interdependence. The authors reported the findings that after unilateral blepharoptosis repair, the mean (± SD) change in contralateral MRD was −0.2 ± 0.8 mm. There was no significant difference in contralateral MRD change in subjects with and without preoperative Hering dependence (−0.3 ± 0.8 mm versus −0.2 ± 0.9 mm, respectively, p = 0.78). Nine out of 54 patients (17%) had a contralateral MRD decrease of more than 1 mm. Three patients (5.6%) required contralateral blepharoptosis repair within 1 year of initial surgery. They concluded that preoperative Hering dependence was poorly predictive of postoperative eyelid position.[6]

In 2008 Wladis et al[7]., in a small study of 12 patients, reported findings of contralateral eyelid height (i.e., intraoperative descent, followed by postoperative elevation) during unilateral ptosis surgery and commented on the relevance in surgical planning. The mean preoperative margin reflex distance on the ptotic side was 0.63 mm versus 3.83 mm contralaterally. No individual demonstrated a Hering phenomenon preoperatively. In each case, the goal was to elevate the ptotic eyelid to the contralateral preoperative height. For the ptotic eyelid, this resulted in a mean intraoperative margin reflex distance of 4 mm. Simultaneously, the contralateral side was noted to drop in each case, to a mean margin reflex distance of 1.67 mm. Postoperatively, at a mean follow up of 1.25 weeks, the mean margin reflex distance values were 3.88 mm and 3.83 mm for the operated and non-operated sides, respectively (Pearson correlation coefficient = 0.88, $p < 0.05$). At a mean follow-up of 4.35 months, the mean margin reflex distance values were 3.80 mm and 3.83 mm for the operated and non-operated sides, respectively (Pearson correlation coefficient = 0.96, $p < 0.05$). No individual had greater than 0.5 mm of asymmetry, and no individual requested postoperative adjustment. Had intraoperative symmetry been obtained with a postoperative contralateral return to preoperative height, a mean 42.1% of postoperative height asymmetry would have resulted between the 2 eyelids. The authors noted that during unilateral levator advancement surgery, the contralateral eyelid temporarily droops, and this Hering-like effect reverses postoperatively. The authors concluded that unilateral ptosis surgery outcomes can be optimized by awareness that the non-surgical eyelid may drop transiently during surgery and return to its normal position postoperatively.[7]

Practice Guidelines and Position Statements

The American Academy of Ophthalmology (AAO)

According to the AAO[5] in 2011, blepharoplasty procedures and repairs of blepharoptosis are considered functional or reconstructive when surgery is done to correct any of the following:

- Visual impairment with near or far vision due to dermatochalasis, blepharochalasis, or blepharoptosis
- Symptomatic redundant skin weighing down the upper lashes
- Chronic, symptomatic dermatitis of pretarsal skin caused by redundant upper lid skin
- Prosthesis difficulties in an anophthalmic socket

American Society of Plastic Surgeons

In 2007, the American Society of Plastic Surgeons (ASPS) published recommended insurance coverage criteria of blepharoplasty for third-party payers[12]. Excerpts from the publication state:

> Blepharoplasty is considered reconstructive when it is performed to correct visual impairment caused by drooping of the eyelids (ptosis) or excess eyelid skin (blepharochalasis); or to repair congenital abnormalities or defects caused by trauma or tumor-ablative surgery.
>
> If two surgical procedures (one reconstructive and one cosmetic) are performed during the same operative session, the surgeon should accurately distinguish which components of the procedure are reconstructive and which are cosmetic.
>
> The ASPS considers blepharoplasty to be cosmetic when it is performed solely to enhance an individual's appearance, in the absence of any signs or symptoms of functional abnormalities. It is the opinion of the ASPS that cosmetic blepharoplasty is not compensable by third-party payers unless specified in the individual's policy.

In 2022, the American Society of Plastic Surgeons developed an evidence-based Clinical Practice Guideline for eyelid surgery for upper visual field improvement[22] and recommended that individuals presenting with low upper eyelid position should have a visual field assessment including the impact on activities of daily living as well as a physical examination assessing

upper eyelid position (ptosis) relative to the pupil (such as MRD-1) with photographic documentation of levator function.

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

In some jurisdictions local coverage determinations (LCDs) may apply. An example LCD[15] policy statement is:

> Blepharoplasty, blepharoptosis repair, and brow ptosis repair (brow lift) are eyelid surgeries that may be functional (i.e., to improve abnormal function) and therefore reasonable and necessary, or cosmetic (i.e., to enhance appearance).

The above medical necessity statement may vary by region; please check local Medicare contractor's LCD if applicable.

References

1. Sacchidanand, SA et al. Transcutaneous Blepharoplasty in Blepharochalasis. J Cutan Aesthet Surg. 2012 Oct; 5(4): 284–286. PMID 23378713
2. Naik MN, et al. Blepharoplasty: An Overview. J Cutan Aesthet Surg. 2009 Jan; 2(1): 6–11. PMID 20300364
3. American Association for Pediatric Ophthalmology and Strabismus. Patient Resources. Source URL: **https://aapos.org/patients/patient-resources** Accessed February 24, 2026.
4. American Academy of Ophthalmology. Diseases and Conditions tab. What is Ptosis? Source URL: **https://www.aao.org/eye-health/diseases/what-is-ptosis** Accessed February 24, 2026.
5. Cahill KV, et al. Functional Indications for Upper Eyelid Ptosis and Blepharoplasty Surgery: a report by the American Academy of Ophthalmology. Ophthalmology 2011; 118 (12): 2510-2517. PMID 22019388 Available at: **http://www.ncbi.nlm.nih.gov/pubmed/22019388** Accessed February 24, 2026.
6. Erb MH, Kersten RC, et al. Effect of unilateral blepharoptosis repair on contralateral eyelid position. Ophthal Plast Reconstr Surg. 2004 Nove; 20(6): 418-22. PMID 15599239 Available at: **http://www.ncbi.nlm.nih.gov/pubmed/?term=15599239** Accessed February 24, 2026.
7. Wladis EJ, Gausas RE. Transient descent of the contralateral eyelid in unilateral ptosis surgery. Ophthal Plast Reconstr Surg. 2008 Sep-Oct;24(5):348-51. PMID: 18806652 Available at: **http://www.ncbi.nlm.nih.gov/pubmed/?term=18806652** Accessed February 24, 2026.
8. Bedran EG, Pereira MV, Bernardes TF. Ectropion. Semin Ophthalmol. 2010; 25(3):59-65. PMID 20590414 Available at: **http://www.ncbi.nlm.nih.gov/pubmed/?term=Ectropion+by+Bedran** Accessed February 24, 2026.

9. Chang S, Lehrman C, Itani K, Rohrich RJ. A systematic review of comparison of upper eyelid involutional ptosis repair techniques: Efficacy and complication rates. Plast Reconstr Surg. 2012;129(1):149-157. PMID: 22186506.

10. American Academy of Ophthalmology (AAO). Functional Indications for Upper and Lower Eyelid Blepharoplasty. Ophthalmic Technology Assessment. Ophthalmology April 1995. 102:693-695.

11. Cohen AJ, Mercandetti M. Ptosis (blepharoptosis) in adults. Medscape reference. Updated August 5, 2024. Available at URL address: **http://emedicine.medscape.com/article/1212082-overview**. Accessed February 24, 2026.

12. Lee MS, Approach to Ptosis. Last updated November 19, 2024. In: UpToDate, Wilterdink JL (Ed), UpToDate, Waltham, MA. **https://www.uptodate.com/contents/approach-to-ptosis?search=Overview%20of%20Ptosis&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1**. Accessed February 24, 2026.

13. American Society of Plastic Surgeons (ASPS). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Blepharoplasty.Re-approved in December 2020. Arlington Heights, IL. American Society of Plastic Surgeons. March 2007.

14. American Society of Plastic Surgeons (ASPS). Practice Parameter for Blepharoplasty. Arlington Heights, IL. American Society of Plastic Surgeons. March 2007.

15. Centers for Medicaid and Medicare Services (CMS). Local Coverage Determination (LCD) for Blepharoplasty, eyelid surgery and brow lift (L36286) Revised. October 1, 2019. Retired. Source URL: **https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=36286** Accessed February 24, 2026.

16. American Society of Ophthalmic Plastic and Reconstructive Surgery, White Paper on Functional Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair, 2015.

17. Sneed PJ. American Academy of Ophthalmology. Upper Eyelid Blepharoplasty. American Academy of Ophthalmology 2025.

18. Hashem AM, Couto RA, Waltzman JT, et al. Evidence-based medicine: A graded approach to lower lid blepharoplasty. Plast Reconstr Surg. 2017;139(1):139e-150e. PMID: 28027251.

19. Kossler AL, Peng GL, Yoo DB, et al. Current trends in upper and lower eyelid blepharoplasty among American Society of Ophthalmic Plastic and Reconstructive Surgery members. Ophthalmic Plast Reconstr Surg. 2018;34(1):37-42. PMID: 28151825.

20. Hollander MHJ, Contini M, Pott JW, et al. Functional outcomes of upper eyelid blepharoplasty: A systematic review. J Plast Reconstr Aesthet Surg. 2019;72(2):294-309. PMID: 30528286.

21. Centers for Medicare & Medicaid Services (CMS). Medical policy article A52837. Blepharoplasty.. Baltimore, MD. Centers for Medicare & Medicaid. Revised January 1, 2025. Available at URL: **https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52837&ver=20&bc=0**. Accessed February 24, 2026.

22. Kim KK, Granick MS, Baum GA, et al. American Society of Plastic Surgeons evidence-based clinical practice guideline: eyelid surgery for upper visual field improvement. Plast Reconstr Surg. 2022; 150(2):419e-434e. PMID: 35895522. Available at URL: **https://journals.lww.com/plasreconsurg/Fulltext/2022/08000/American_Society_of_Plastic_Surgeons.39.aspx** . Accessed February 24, 2026.

23. Oculofacial Society. Procedures/Droopy eyebrows and brow lift surgery. 2025. Available at URL address: **https://www.oculofacialsociety.org/procedure/excess-eyelid-skin-and-droopy-brows/** . Accessed February 24, 2026.

24. Kokubo K, Katori N, Hayashi K, Fujiwara B, Oi K, Ikeda H, Hayashi A. What Stage of Intraoperative Margin Reflex Distance Should be Used as a Guide in Blepharoptosis Repair? J Craniofac Surg. 2025 Feb 5. doi: 10.1097/SCS.0000000000011130. Epub ahead of print. PMID: 39907243.

25. Alfano C, Chiummariello S, De Gado F, et al. Lateral canthoplasty -- 10-year experience. Acta Chir Plast. 2006;48(3):85-88. PMID: 17165595.

26. Aiello F, Gallo Afflitto G, Alessandri Bonetti M, et al. Lax eyelid condition (LEC) and floppy eyelid syndrome (FES) prevalence in obstructive sleep apnea syndrome (OSA) patients: a systematic review and meta-analysis. Graefes Arch Clin Exp Ophthalmol. 2023 Jun;261(6):1505-1514. PMID: 36380123.

27. Cheong AJY, Ho OTW, Wang SKX, et al. Association between obstructive sleep apnea and floppy eyelid syndrome: A systematic review and metaanalysis. Surv Ophthalmol. 2023 Mar-Apr;68(2):257-264. PMID: 36427560.

28. American Academy of Ophthalmology (AAO). EyeWiki. Canthoplasty. January 27, 2026.

29. American Academy of Ophthalmology (AAO). EyeWiki. Floppy Eyelid Syndrome. September 28, 2025

History

Date	Comments
02/02/99	Add to Surgery Section - New Policy
10/08/02	Replace Policy - Policy reviewed without literature review; new review date only.
07/08/03	Replace Policy - Scheduled review; no change to policy statement.
01/01/04	Replace Policy - CPT code updates only.
07/13/04	Replace Policy - Scheduled review; no change to policy statement.
09/01/04	Replace Policy - Policy renumbered from PR.7.01.108. No date changes.
06/14/05	Replace Policy - Policy reviewed; no change to policy statement.
01/10/06	Replace Policy - Policy reviewed; policy statement changed with the removal of "The medical history must also document corneal abrasion due to the lashes" indication. Review scheduled changed to January AND the policy status changed to AR.
02/06/06	Codes updated - No other changes.
01/09/07	Replace Policy - Policy statement reorganized with the addition of brow ptosis as medically necessary treatment when specific criteria are met; criteria differentiated between treatment based upon the presence of ectropion or entropion. Title changed to include "and Brow Ptosis".
01/08/08	Replace Policy - Policy updated with literature search. No change in policy statement. Status changed from AR to PR.
05/12/09	Replace Policy - Policy updated with literature search. Minor updates made to the policy statement, intent of policy remains unchanged. Description and Policy guidelines updated. References added.
06/06/09	Disclaimer and Scope update - No other changes.
02/09/10	Replace Policy - Policy updated with literature search. No change to policy statement.
02/08/11	Replace Policy - Policy updated with literature search. No change to policy statement. Reference removed.
09/23/11	Related Policies updated; 10.01.514 added.

Date	Comments
02/14/12	Replace Policy - Policy updated with literature search. No change to policy statement. Reference added.
07/10/12	Replace policy. Removed policy statement "any related disease process; such as myasthenia gravis, hypothyroidism or nerve palsy is documented as stable" at request of clinical review. Other edits to policy statement for clarification. Added clarification to the policy guidelines about the patient medical records submitted for review.
05/28/13	Replace policy. Added the word "surgery" to the title. Policy statement revised with addition of medical necessity statement for children with obstructed vision. Clarification added to say: "Lower lid blepharoplasty for removal of excess tissue such as skin or fat is considered **cosmetic** in the absence of ectropian/entropian or functional impairment". Rationale section updated base on a literature review through March 2013. References 1-5 added, others renumbered or removed. Policy statement revised as noted.
05/05/14	Annual Review. Policy reviewed. Moved definition of terms from Benefit Application section to Policy Guidelines. A literature search through March 2014 did not prompt any changes to the rationale section. No new references added. Policy statement unchanged.
11/10/14	Interim Update. Title changed to include blepharoptosis. Policy statement added clarifying bilateral surgery determination when only one eye meets medically necessity stating that surgery on the unaffected eye is considered cosmetic. Levator resection removed from blepharoplasty policy statement. New policy statement for blepharoptosis with criteria for adults was added. Moved Definitions of terms from Description to Policy Guidelines section. Rationale updated with literature review through September, 2014. Practice Guidelines and Position Statements section added. References 6-7, 15 added; others renumbered/removed. CPT 67011 removed – does not apply to this policy. Policy statement changed as noted.
05/12/15	Annual Review. Policy updated with literature review through March 2015. Added policy statement "Blepharoplasty is considered not medically necessary when an eyelid ectropion or entropion does not meet criteria stated in the policy. (See Policy Guidelines for documentation.)". Added lateral photos as required documentation for submission. Ptosis surgery statement now says that BOTH margin reflex distance (MRD) AND photos must document vision impairment. Rationale section reformatted. References renumbered; no additions made. Policy statements revised as noted.
06/09/15	Interim update. Policy statement is added, for upper eyelid blepharoplasty or blepharoptosis surgery in children, that frontal/full face and lateral photos are required. The photos must document visual impairment. No other changes made. CPT codes 67914-17, 67921-24 removed; these are not reviewed.
12/08/15	Interim review. CPT codes added to the relevant policy statements. The Policy Guidelines information put in table format for usability. Policy statements unchanged.
05/01/16	Annual review, approved April 12, 2016. Policy statements unchanged Literature Review. No references added.

Date	Comments
03/01/17	Annual Review, approved February 14, 2017. Policy reviewed with literature search, no new references added. Policy moved into new format, no change to coverage.
03/01/18	Annual Review, approved February 13, 2018. Reference removed. Policy rewritten for clarity. Blepharoplasty,blepaharoptosis repair, or brow lift in the absence of a functional impairment, as well as lower lid blepharoplasty in the absence of ectropian or entropian, and surgery of an unaffected eye changed to not medically necessary instead of cosmetic.
09/01/18	Minor update. Re-added Consideration of Age information, which was inadvertently removed during a previous update.
03/01/19	Annual Review, approved February 5, 2019. Literature Review. References 16-17 added. Reference 15 updated. No change to policy statements other than minor edits for clarity.
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.
06/10/20	Interim Review, approved June 9, 2020, effective June 10, 2020. This policy is reinstated immediately and will no longer be deleted or replaced with InterQual criteria on July 2, 2020.
09/01/20	Annual Review, approved August 4, 2020. Policy reviewed, policy statements unchanged. References updated. No new references added.
04/01/21	Annual Review, approved March 23, 2021. Policy reviewed. References added. Policy statements unchanged. Coding update, remove CPT 67909.
03/01/22	Annual Review, approved February 21, 2022. Policy reviewed. References added and updated. Policy statements unchanged.
03/01/23	Annual Review, approved February 20, 2023. Policy reviewed. References added and updated. Policy statements unchanged except for minor edits changing the wording from "patient" to "individual" throughout the policy for standardization.
08/01/24	Annual Review, approved July 22, 2024. Policy reviewed. References updated. Policy statements unchanged.
09/01/25	Annual Review, approved August 25, 2025. Policy reviewed. References added and updated. Changed policy statements on blepharoplasty, blepharoptosis repair, brow lift, lower eyelid blepharoplasty, and bilateral surgery in the absence of signs or symptoms of a functional impairment that do not meet the medical necessity criteria of the policy from not medically necessary to cosmetic.
11/18/25	Minor update, spelling correction.
04/01/26	Annual Review, approved March 10, 2026. Policy reviewed. References updated. References added. Added policy statement that canthoplasty/canthopexy may be considered medically necessary to correct reconstructive indications/functional impairments when criteria are met. Added CPT codes 21280, 21282, and 67950.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.