Molina Clinical Policy
Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair
Policy No. 204

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This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Blepharoptosis, pseudoptosis, dermatochalasis, blepharochalasis, brow ptosis, and **blepharospasm,** are all periocular conditions that can impact vision, ocular function, and quality of life. They may cause obstruction of the visual field, discomfort, or interfere with daily activities.

Blepharoptosis is an abnormal drooping of the upper eyelid due to dysfunction of the levator or Muller's muscle. In severe cases, the eyelid can obstruct the pupil and cause significant visual field impairment (ASPS 2020; Koka and Patel 2023).

Pseudoptosis refers to the appearance of upper eyelid drooping that is not caused by dysfunction of the levator or Muller's muscle dysfunction but instead results from abnormalities in surrounding structures. Conditions such as dermatochalasis, brow ptosis, hypotropia, globe size and volume abnormalities (conditions in which the eye is abnormally small, absent, or significantly decreased in volume), including microphthalmos, anophthalmos, and phthisis bulbi, or contralateral eyelid retraction can alter eyelid contour or coverage in a way that mimics true ptosis despite normal eyelid function (Koka and Patel 2023).

Congenital ptosis is a form of true ptosis in which abnormal drooping of the upper eyelid is present at birth or becomes apparent within the first year of life. It most commonly results from congenital maldevelopment of the levator muscle, leading to reduced levator function and an absent or poorly formed eyelid crease. Severe cases may obstruct the visual access and interfere with normal visual development (Shukla and Patel 2023).

Dermatochalasis is characterized by redundant, inelastic upper eyelid skin that results from gradual atrophy of connective tissue and loss of skin elasticity. It is primarily associated with aging and can lead to hooding over the upper eyelid, causing visual field obstruction, brow strain, and tension headaches (ASPS 2020; Patel and Malhotra 2023).

Blepharochalasis, also characterized by redundant and sagging skin of the upper eyelids, is a rare inflammatory condition that causes recurrent episodes of eyelid edema and can lead to progressive skin atrophy and laxity. Patients with this condition may develop a secondary ptosis due to the weight of the redundant skin contributing to obstruction of the visual field. It is more common in adolescence or young adulthood (Ortiz-Perez and Patel 2025).

Brow ptosis is a drooping of the eyebrows due to loss of support from the surrounding facial structures. Like dermatochalasis, it is primarily associated with aging and can contribute to upper eyelid hooding, leading to visual field obstruction, strain, and headaches. Brow ptosis is often evaluated in conjunction with dermatochalasis and blepharoptosis, as these conditions may coexist and contribute to functional impairment (De Jong and Hohman 2025).

Blepharospasm is a neurological disorder characterized by involuntary, repetitive contractions of the orbicularis oculi muscles, leading to excessive blinking or forceful eyelid closure. The condition can progress to persistent eyelid closure, resulting in functional blindness despite an otherwise normal visual system (Titi-Lartey and Patel 2023).

Blepharoplasty, blepharoptosis repair, and **brow ptosis repair** are surgical procedures that can correct periocular conditions that impact vision, ocular function, and quality of life. Blepharoplasty primarily treats dermatochalasis,

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blepharochalasis, and pseudoptosis by removing excess skin, muscle, or fat from the upper or lower eyelids. Blepharoptosis repair restores proper eyelid elevation and improves visual function in patients with levator or Muller's muscle dysfunction. Brow ptosis repair elevates the position of the eyebrows to reduce ptosis and alleviate upper eyelid hooding. While blepharoplasty and brow ptosis repair are commonly performed for cosmetic reasons, functional or reconstructive surgery is indicated when the periocular condition obstructs vision or interferes with quality of life (ASPS 2020; De Jong and Hohman 2025; Patel and Malhotra 2023).

COVERAGE POLICY

Medically Necessary

The following surgical procedures may be **considered medically necessary** when ALL the criteria for the requested procedure are met. *If multiple procedures are requested, the criteria for each procedure must be met*:

1. Upper eyelid blepharoplasty may be considered medically necessary for ONE of the following:
   a. Correction of ptosis associated with an ocular prosthesis, when ALL the following are present:
      i. Diagnosis of ptosis due to an ocular prosthesis
      ii. Documented functional impairment (e.g., chronic irritation, poor fit, difficulty retaining prosthesis)
   b. Correction of upper eyelid tissue causing functional impairment, when ALL the following are present:
      i. Documented functional visual complaints or impairment related to eyelid abnormality
      ii. Diagnosis of ANY of the following:
         1) Blepharochalasis
         2) Dermatochalasis
         3) Pseudoptosis
         4) Congenital or pediatric ptosis
      iii. Visual field testing shows superior field loss ≥ 20 degrees that is corrected with manual elevation of the upper lid margin (e.g., taping) (not required for children ages 12 and under)
      iv. Frontal or lateral photographs demonstrating visual field limitation consistent with examination

2. Upper eyelid blepharoptosis repair may be considered medically necessary for ONE of the following:
   a. Correction of ptosis associated with an ocular prosthesis, when ALL the following are present:
      i. Diagnosis of ptosis due to an ocular prosthesis
      ii. Documented functional impairment (e.g., chronic irritation, poor fit, difficulty retaining prosthesis)
   b. Correction of upper eyelid tissue causing functional impairment, when ALL the following are present:
      i. Documented functional visual complaints or impairment related to eyelid abnormality
      ii. Diagnosis of ANY of the following, with other reversible causes of ptosis excluded (e.g., Botox injections, nerve palsy that does not recover within 6-12 months):
         1) Blepharoptosis
         2) Congenital or pediatric ptosis
      iii. Upper eyelid Margin Reflex Distance-1 is ≤ 2.0 mm from mid-pupil in primary gaze
      iv. Visual field testing shows superior field loss ≥ 20 degrees that is corrected with manual elevation of the upper lid margin (e.g., taping) (not required for children ages 12 and under)
      v. Frontal or lateral photographs demonstrating visual field limitation consistent with examination

3. Brow ptosis repair may be considered medically necessary when ALL the following are present:
   a. Documented functional visual complaints related to brow ptosis and/or associated eyelid abnormality
   b. Diagnosis of brow ptosis
   c. Visual field testing shows superior visual field loss ≥ 20 degrees of vision that is corrected with manual elevation of the brow (e.g., taping)
   d. Frontal or lateral photographs demonstrating that the eyebrow is below the supraorbital rim and that demonstrate visual field limitation consistent with examination

4. Lower eyelid blepharoplasty may be considered reconstructive and medically necessary when ALL the following are present:
   a. Diagnosis of ANY of the following:

i. Blepharospasm with apraxia of the lid opening
ii. Lower eyelid dermatochalasis causing inability to close the eyelid (e.g., lagophthalmos)
iii. Ptosis due to an ocular prosthesis

b. Documented functional impairment, such as uncontrolled tearing, irritation, or dry eye
c. Conservative treatments have been tried and failed (e.g., Botox injections for blepharospasm)

Not Medically Necessary

Procedures performed solely for **cosmetic purposes**, such as blepharoplasty, blepharoptosis repair, or brow ptosis repair, without significant functional impairment and without a reasonable expectation of functional improvement, are considered cosmetic in nature and **are not medically necessary.**

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Systematic Reviews and Meta-Analyses

Rodriguez at al. (2023) completed a systematic review and meta-analysis evaluating functional and anatomical outcomes following upper eyelid blepharoplasty across 20 studies, totaling 630 patients undergoing surgery for dermatochalasis or age-related upper eyelid changes. Nine studies were included in the quantitative meta-analysis. Across pooled analyses, the authors found no significant postoperative changes and flattest keratometry (K1; mean difference 0.09 D, where D = diopters, the standard unit of corneal refractive power), steepest keratometry (K2; mean difference -0.20 D), corneal astigmatism (mean difference 0.0 1D), intraocular pressure(mean difference 0.32 mmHg), or tear film breakup time (mean difference 0.55 seconds). The pooled outcomes support that upper eyelid blepharoplasty does not adversely affect corneal curvature, refractive parameters, intraocular pressure, or tear film stability. Patient satisfaction was consistently high, and complication rates were low across included studies. Overall, the review supports that upper eyelid blepharoplasty is a functionally safe procedure with stable ocular surface and refractive outcomes.

Karam et al. (2023) conducted a systematic review and meta-analysis to compare the outcomes of Muller's muscle conjunctival resection (MMCR) and external levator advancement (ELA) for ptosis repair. The review included seven studies, consisting primarily of non-randomized comparative cohort studies, and one randomized controlled trial (RCT), for a total of 1038 eyelids (n = 1038). The primary outcomes assessed were post-operative marginal reflect distance (MRD1), rate of ptosis under-correction and over-correction, and re-operation rates. The results showed no statistically significant difference between MMCR and ELA in post-operative MRD1 (MD = 0.13, p = 0.28), or under-correction rates (OR = 0.49, p = 0.14). ELA was associated with significantly higher rates of over-correction (OR = 0.17, p =0.04) and re-operations (OR = 0.26, p = 0.0001) compared to MMCR. Among secondary outcomes MMCR was associated with improved cosmetic appearance, fewer total complications, and significantly shorter operation time (MD = -10.96, p < 0.00001). The authors concluded that both MMCR and ELA are effective surgical techniques for ptosis repair, but MMCR is a more predictable procedure in the appropriate patient setting, particularly for those with mild-to-moderate ptosis and a positive phenylephrine test.

Lim et al. (2022) conducted a systematic review to evaluate the efficacy and complication rates of external and internal pediatric blepharoptosis repair techniques. The review included 23 nonrandomized studies (20 case series and 3 retrospective cohort studies), for a total of 730 pediatric patients (n = 730). The review found that external levator resection was the most frequently studied technique, with 18 studies assessing its outcomes. Internal approaches, including the Fasanella-Servat procedure, were examined in seven studies. No RCTs were identified, and overall study quality was low. Surgical efficacy was not standardized across studies, and definitions of success varies. Reoperation rates were reported at 16.6% (ranging from 3.6% to 50.9%) for external levator resection and 22.2% (ranging from 0.0% to 25.8%) for internal approaches. The most common complication reported was under correction, occurring in 8.4% (ranging from 2.4% to 16.7%) of external levator resections and in 15.3% (ranging from 2.7% to 75.0) of internal procedures. While rare, postoperative complications such as lagophthalmos, entropion, and corneal scarring leading

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to amblyopia were reported in some cases. For external levator resection, efficacy was evaluated based on MRD1, palpebral aperture measurements, and subjective assessments of surgical success. Studies reported a wide range of surgical success rates, with some achieving 72.7% to 93.8% optimal results. Refractive changes following surgery were noted, with a statistically significant postoperative increase in astigmatism in some studies, raising concerns about potential amblyogenic effects. Internal levator resection had fewer studies supporting their use, with small sample sizes and lack of robust methodology limiting comparisons with external techniques. The Fasanella-Servat technique reported success rates of 83.3% to 92.9% in two studies, but one study found under correction in 3 of 4 cases. The authors concluded that both external and internal surgical techniques for pediatric blepharoptosis repair have been used successfully in practice. However, because there are no high-quality, well designed comparative studies, it is difficult to determine which approach is best in terms of safety, effectiveness, and long-term outcomes.

Hollander et al. (2019) completed a large systematic review on subjective and objective functional effects of upper eyelid blepharoplasty. The reviewers assessed a total of 3,525 studies and selected 28 for the inclusion in the systematic review. Eligible studies were RCTs, controlled trials, cohort studies and case series (n ≥ 10). The intervention was solitary surgical upper blepharoplasty containing the removal of skin, with or without the removal of a strip of orbicularis oculi muscle and/or upper orbital fat. Outcome variables included dry eyes, upper visual field, eyebrow height, shape of cornea, sensitivity of upper eyelid skin, contrast sensitivity, eyelid kinematics and quality of life aspects. The authors concluded that upper blepharoplasty had beneficial outcomes of increased visual field, headache improvement and vision related quality of life, such as decreased sensitivity of the upper eyelid skin. It was noted that they recommend further research for conflicting results (effects on eye dryness and eyebrow height) and/or the areas where the data was limited (contrast sensitivity, astigmatism). Limitations of this systematic review include that the studies included in this review were mostly of female participants, thus the finding cannot be generalized to male participants, and there was a lack of standardization of surgical technique among the studies chosen for inclusion.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence
Ha et al. (2007) published a retrospective case series evaluating the clinical effects of conjunctive-Muller muscle resection in anophthalmic patients with mild ptosis. The study included 8 patients (8 eyes) who had received evisceration or enucleation and responded to 10% phenylephrine solution to correct ptosis. Ptosis was observed between one and 34 months after eye removal. Prior to surgery, the MRD1 ranged from -2 mm to 0.5 mm, with an average of 0.25 mm (± 1.10 mm). After phenylephrine application, MRD 1 improved by an average of 2.56 mm (± 0.98 mm). The Muller muscle was resected in increments of 7.5 to 9 mm to achieve symmetry with the contralateral eye. The follow-up period ranged from 2 to 16 months, with an average of 8.1 months. Postoperatively, MRD1 improved by an average of 1.81 mm (± 0.88 mm). This was slightly less than the improvement observed after phenylephrine testing, but all patients except one achieved an MRD1 within 1 mm of the contralateral eye, indicating a successful outcome. No significant postoperative complications were reported. The authors concluded that conjunctiva-Muller muscle resection is a reliable method for correcting mild ptosis in anophthalmic patients, particularly when preserving the stability of the upper eyelid is a priority.

National and Specialty Organizations

The **American Society of Plastic Surgeons (ASPS)** *Evidence-Based Clinical Practice Guideline*: *Eyelid Surgery for Upper Visual Field Improvement* provides recommendations on diagnosis and surgical management for upper visual field impairments caused by eyelid ptosis and dermatochalasis. Neonatal and young pediatric (infancy to preadolescence) are excluded from the guideline. The ASPS highlights that upper eyelid surgery is functional and not cosmetic when it addresses visual field obstruction. A comprehensive evaluation should include clinical history, objective assessment of impact on visual field or activities of daily living, and a physical examination assessing upper eyelid position relative to the pupil. The examination should assess whether the cause of visual field obstruction is due to excess skin (dermatochalasis) or low position of the eyelid margin (blepharoptosis). The MRD1 and levator function should be assessed, and photographs of the eyelid should be taken. The guideline does not recommend blepharoplasty alone (i.e., without ptosis correction) for patients with diagnosed ptosis; instead, concurrent blepharoplasty and ptosis correction should be performed when indicated. In patients with dermatochalasis without underlying ptosis, blepharoplasty is recommended. Brow ptosis repair is optional but may be necessary in cases of significant brow descent (Kim et al. 2022).

The **American Academy of Ophthalmology (AAO)**, in a report on the functional indications for upper eyelid ptosis and blepharoplasty surgery, note that ptosis and dermatochalasis can independently impair visual field and patient

well-being. Based on a review of 13 studies, repair of blepharoptosis and upper eyelid dermatochalasis provides significant improvement in vision, peripheral vision, and quality of life activities. Ptosis and upper eyelid blepharoplasty were found to be functionally beneficial for each of these quantitative findings:

1. MRD1 of ≤2 mm measured in primary gaze
2. Superior visual field loss of 12 degrees or 24%
3. Down-gaze ptosis impairing reading documented by MRD1 of ≤2 mm measured in down gaze
4. Self-reported functional impairment from upper eyelid droop
5. Chin-up backward head tilt induced by visual field impairment caused by lids
6. Interference with occupational duties and safety resulting from visual impairment caused by the upper lids
7. Symptoms of discomfort, eye strain, or visual interference due to the upper eyelid position

The AAO did not find strong data supporting ptosis or blepharoplasty surgery for dermatitis, difficulty wearing a prosthesis in an anophthalmic socket, or temporal visual field impairment preventing a driver from meeting licensing standards (Cahill et al. 2011).

SUPPLEMENTAL INFORMATION

Visual field testing: measures the extent of a patient's central and peripheral vision in degrees. In a normal eye, the visual field extends approximately 60° superiorly, 75° inferiorly, 60° nasally, and 90 - 100° temporally (Leavitt 2021). Superior field deficits are the pattern most commonly associated with upper eyelid malposition, as redundant skin or ptosis can obstruct the upper portion of the visual field.

Margin Reflex Distance 1: The upper margin reflex distance (MRD1) is the distance between the corneal light reflex to the upper eyelid margin. The normal MRD1 for the upper eyelid is 4 to 5 mm above the mid-pupil (Koka and Patel 2023).

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
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
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	Reduction of overcorrection of ptosis

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APPROVAL HISTORY

04/08/2026	Policy reviewed. No changes to coverage criteria. Updated Overview, Summary of Medical Evidence and References.
04/09/2025	Policy revised. Removed diagnosis stipulation from "ONE" to "ANY" for blepharoplasty and blepharoptosis repair. Removed visual field test requirement for children ages 12 and under for upper eyelid blepharoplasty in addition to blepharoptosis repair. Separated ocular prosthesis with its own criteria under upper eyelid blepharoplasty and blepharoptosis repair. Added diagnosis of brow ptosis as a criterion for brow ptosis repair. Removed "congenital or pediatric ptosis and ptosis due to an ocular prosthesis" as implied indications for brow ptosis repair. Edited coverage policy for conciseness and clarity. IRO peer reviewed on March 24, 2025, by a practicing physician board certified in Ophthalmology.
04/10/2024	Policy reviewed. Updated Summary of Medical Evidence and References. Congenital or pediatric ptosis removed from lower eyelid indications as it is addressed in upper eyelid blepharoptosis repair indications. IRO Peer Review on March 18, 2024, by a practicing physician board-certified in Ophthalmology.
04/13/2023	Policy reviewed, added clarification that visual field testing is not necessary for children ages 12 and under (for upper eyelid blepharoptosis repair).
04/13/2022	Policy reviewed; no changes to criteria; updated Summary of Medical Evidence and Reference sections.
04/05/2021	Policy reviewed, no changes to criteria.
06/17/2020	Policy reviewed, clinical criteria changed based on new guidelines, updated references. Added the following diagnoses as medically appropriate conditions: congenital or pediatric ptosis or ptosis due to an ocular prosthesis. Added blepharospasm and removed nerve damage from the criteria for lower eyelid blepharoplasty to be consistent with new guidelines. IRO Peer Review on March 3, 2020, by a practicing physician board-certified in Ophthalmology.
06/19/2019	Policy reviewed, no changes to criteria.
03/08/2018	Policy reviewed, no changes to criteria.
09/19/2017	Policy reviewed, no changes to criteria.
09/15/2016	Policy reviewed, no changes to criteria.
12/16/2015	Policy reviewed, no changes to criteria.

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