MEDICAL POLICY

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Medical Policy Title	**Blepharoplasty and Brow Ptosis Repair**
Policy Number	**7.01.55**
Current Effective Date	**March 19, 2026**
Next Review Date	**March 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

POLICY STATEMENT(S)

Blepharoplasty

I. Upper eyelid blepharoplasty (reconstructive or functional) with or without functional levator muscle advancement, is considered **medically appropriate** for **ANY** of the following indications:

A. Ptosis when **ALL** the following are documented (See Policy Guidelines):

1. Upper eyelid margin is approaching less than or equal to 2.5 mm (1/4 of the diameter of the visible iris) of the corneal light reflex (marginal reflex distance or MRD);
2. Photographs in primary gaze (head and gaze straight ahead) demonstrating light reflex;
3. Functional limitations to the patient's vision; **and**
4. Visual field testing, with a written interpretation, demonstrates a minimum of 30 percent loss of upper field of vision with upper lid skin or upper margin in repose and an increase of 12 degrees or more with elevation (by the taping of the lid) to demonstrate potential correction by proposed procedure or procedures.

B. Dermatochalasis when **ALL** the following are documented (See Policy Guidelines):

1. Severe, redundant skin resting upon the eyelashes;
2. Photographs in primary gaze and/or lateral view showing eyelid tissue resting on or pushing down on the eyelashes;
3. Functional limitations to the patient's vision; **and**
4. Visual field testing, with a written interpretation, demonstrates a minimum of 30 percent loss of upper field of vision with upper lid skin or upper margin in repose and an increase of 12 degrees or more with elevation (by the taping of the lid) to demonstrate potential correction by proposed procedure or procedures.

C. Anophthalmia Socket when **ALL** the following are documented (See Policy Guidelines):

1. Improper fit of the eye prosthesis;
2. Difficulty wearing the prosthesis is caused by eyelid abnormality; **and**

3. Photographs showing the abnormality.

II. Lower eyelid blepharoplasty (reconstructive or functional) is considered **medically necessary** for **ALL** the following (See Policy Guidelines):

A. Diagnosis of **EITHER** of the following:

1. Vision is obstructed by the excess tissue; **or**
2. Eyes are dry and irritated; **and**

B. Clinical documentation includes **EITHER** of the following:

1. Functional limitation to the patient's vision; **or**
2. Eye irritation as shown in photographs and documentation of treatment.

III. Revisional blepharoplasty is considered **medically appropriate** when the criteria stated in Policy Statement I or II are met.

IV. If unilateral disease meets the above criteria, blepharoplasty of the opposite eyelid at the same time, may be considered **medically appropriate** as bilateral reconstructive blepharoplasty when **ALL** the following are met:

A. The opposite eyelid also exhibits abnormalities;

B. The opposite eyelid does not yet meet criteria for reconstructive blepharoplasty;

C. Clinical evidence indicates that the opposite eyelid will soon meet criteria for reconstructive blepharoplasty.

V. Cosmetic blepharoplasty is considered **not medically necessary** when performed to improve a patient's appearance, in the absence of any signs or symptoms of functional abnormalities.

Brow Ptosis Repair

VI. Brow ptosis repair (brow lift or browpexy) is considered **medically appropriate** when **ALL** the following are documented (See Policy Guidelines):

A. Brow ptosis causes functional visual impairment;

B. Photographs (lateral view preferred) showing the eyebrow below the supraorbital rim;

C. Visual field testing with a written interpretation.

RELATED POLICIES

Corporate Medical Policy

7.01.11 Cosmetic and Reconstructive Procedures

POLICY GUIDELINE(S)

I. Peripheral visual field testing should be performed with the eyelid and brow in the resting position to document a baseline superior visual field of 30 degrees or less from fixation and show

an improvement of at least 12 degrees over baseline with eyelid and brow elevation. A superior visual field of 30 degrees or less that improves with eyelid and brow elevation corresponds to a functional superior visual field loss. If visual field testing is unable to be performed, a written explanation with photographs must accompany the request.

II. Documentation of the marginal reflex distance (MRD), which is the number of millimeters from the corneal light reflex or center of the pupil to the upper lid margin, is necessary for ptosis evaluation. For dermatochalasis MRD is not necessary but may be sufficient.

III. Photographic documentation of the patient while looking in primary gaze, upward-gaze, downward-gaze, and lateral views, which must be consistent with the degree of visual field impairment described in the medical records or demonstrated by the MRD measurements.

IV. Functional limitations may include:

A. Significant interference with vision or superior or lateral visual field (e.g., difficulty seeing objects approaching from periphery);

B. Difficulty reading due to superior visual field loss;

C. Looking through the eyelashes or seeing the upper eyelid skin; or

D. Significant congenital or acquired deformities or deformities beyond normal variations and accompanied by functional deficits. These must be evidenced by photographs. In some cases, visual fields may also be required.

DESCRIPTION

Blepharoplasty is eyelid surgery performed to remove fat, usually along with excess skin, from the upper and lower eyelids.

A functional blepharoplasty is performed when the range of vision is narrowed due to excessive redundant skin in the eyelid (dermatochalasis). During this procedure, various amounts of excess skin and sometimes fat are removed from the upper eyelid, thus increasing vision range. A blepharoplasty may be performed alone or in conjunction with other facial surgery procedures, such as a face lift or browlift, or to address cosmetic issues; however, it will not remove crow’s feet or other wrinkles, eliminate dark circles under eyes, or lift sagging eyebrows.

Pseudoptosis is a condition in which the upper-lid skin becomes redundant and lax to such an extent that it "hoods" the eye, blocking peripheral vision on upward-gaze or the upper visual field when looking straight ahead. Dermatochalasis and/or muscle laxity is corrected with a reconstructive upper-lid blepharoplasty that removes excess tissue and restores visual function.

Eyelid ptosis, or blepharoptosis, is when the upper eyelid descends from its normal position or drops to approach or cover the pupil in one or both eyes. This condition can be caused by weakness of the levator muscle or tendon that lifts the eyelid. Treatment when vision is impaired is called a levator muscle advancement and involves tightening the levator muscle to lift the eyelid. In very severe cases involving weakened levator muscles, the eyelid is attached under the eyebrow. This allows the forehead muscles to substitute for levator muscles in lifting the eyelid. A blepharoplasty may be

performed along with levator muscle advancement when dermatochalasis is also present.

Cosmetic Blepharoplasty

When blepharoplasty is performed to improve a patient's appearance, in the absence of any signs and/or symptoms of functional abnormalities, the procedure is considered cosmetic.

Reconstructive Blepharoplasty

Reconstructive blepharoplasty is performed:

- to correct visual impairment caused by drooping of the eyelids (ptosis);
- to correct severe redundant skin (dermatochalasis) resting upon the eyelashes;
- to repair defects caused by trauma or tumor-ablative surgery;
- to treat periorbital sequelae of thyroid disease and nerve palsy;
- to relieve the painful symptoms of blepharospasm. This may involve rearrangement or excision of the structures within the eyelids and/or tissues of the cheek, forehead, and nasal areas.

Signs and symptoms commonly found in association with ptosis, pseudoptosis, blepharochalasis, and/or dermatochalasis include, but are not limited to, the following:

- visual field impairment in primary or downward gaze (e.g., reading position);
- lower than normal position of the eyelid relative to the pupil;
- excess skin that hangs over the edge of the eyelid;
- chronic dermatitis due to redundant skin;
- patients with anophthalmic socket experiencing prosthesis difficulties.

Primary essential (idiopathic) blepharospasm is a condition characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. Treatment includes extended blepharoplasty with wide resection of the orbicularis oculi muscle complex.

Cranial nerve palsy is the partial or complete palsy of the facial (seventh cranial) nerve or the oculomotor (third cranial) nerve and can cause true ptosis or pseudoptosis from marked periorbital muscle paralysis. Symptoms such as exposure keratitis and cornea erosion (facial nerve) or visual restriction (oculomotor nerve) may occur. When lesions involving the temporal branch of the facial nerve are present, treatment consists of reconstructive blepharoplasty, with or without browlift. Third-nerve palsy may require frontalis fascial suspension to obtain an adequate eyelid.

Thyroid disease symptoms may include unilateral or bilateral upper-eyelid retraction and proptosis (protruding eye). Frequently, medical therapy for the thyroid pathology will resolve these deformities, but occasionally, reconstructive blepharoplasty is necessary to prevent corneal exposure and erosion.

SUPPORTIVE LITERATURE

Ulas et al (2024) published results of a prospective study to evaluate the effect of upper eyelid blepharoplasty surgery on corneal topography, visual field, ocular surface, meibography, corneal biomechanics and dry eye parameters. A total of 80 eyes of 40 patients were included. Following a

detailed ophthalmological examination, standardized patient satisfaction questions were posed to patients before and after upper eyelid blepharoplasty surgery. Visual field test, non-invasive break up time (NIBUT), meibography, and corneal topography parameters were analyzed and evaluated. The mean (+) visible areas in the visual field were found to be 46.20±24.96 preoperatively, 56.73±21.98 at the 1st postoperative month and 65.96±18.5 at the 3rd month, which were statistically significant. NIBUT values preoperatively, at 1 month and at 3 months were 11.26±4.48, 11.16±4.5 and 10.14±4.0, respectively, which were statistically significant. Meibomian gland loss rates on meibography preoperatively and postoperatively at 1 and 3 months were found to be 30.24±8.3, 29.36±8.2 and 28.22±7.7 respectively and were statistically significant. With the scoring system after blepharoplasty, patients reported improvement in their symptoms. The authors concluded that upper eyelid blepharoplasty surgery is predicted to increase the quality of vision. It was observed that there was a functional and cosmetic improvement in the complaints of the patients after blepharoplasty. However, blepharoplasty may cause changes in eyelid dynamics and cause dry eye syndrome.

Hollander et al (2019) published results of a systematic review to assess the objective and subjective functional effects of upper blepharoplasty found in published literature. A total of 3525 studies were assessed, of which 28 studies were included. The intervention was defined as a 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. Eligible studies were randomized controlled trials, controlled trials, cohort studies, and case series ($n \geq 10$). Favorable outcomes after an upper blepharoplasty were reported and included enlarged visual field, enhanced quality of life related to fewer headaches and improved vision. Furthermore, sensitivity of the eyelids decreased, with differences in recovery. Outcomes for eyebrow height, astigmatism, contrast sensitivity, and eyelid kinematics were not consistent between the studies. No meta-analysis could be performed due to the limited scope of included studies and the great variety in outcomes and blepharoplasty techniques. The authors concluded, upper blepharoplasty is accompanied by a great variety of beneficial functional outcomes including an increased visual field and improvement in headache- and vision-related quality of life. Further research is needed, especially where results are conflicting (effects on eye dryness and eyebrow height) and/or the data are limited (contrast sensitivity, astigmatism).

PROFESSIONAL GUIDELINE(S)

The American Academy of Ophthalmology (AAO) published a report of Functional Indications for Upper Eyelid Ptosis and Blepharoplasty Surgery (Cahill 2011) that state blepharoplasty surgery was found to be functionally beneficial for the following quantitative findings: a MRD1 of ≤ 2 mm measured in primary gaze or a superior visual field loss of 12 degrees or 24%. They explain the unobstructed normal superior field measures approximately 50 degrees. Visual field impairment can occur when the MRD1 is less than 4 mm. With an MRD1 of 2 mm, the superior visual field impairment is in the range of 24–30%. This corresponds to 12-15 degrees of superior visual field loss. Preoperative indicators of improvement include margin reflex distance 1 (MRD1) 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.

AAO published a technology assessment regarding health-related quality of life (HRQL) outcomes for upper blepharoplasty and blepharoptosis surgery (Vagefi 2025). A meta-analysis of 20 studies utilizing validated instruments to assess HRQL and found blepharoptosis correction beneficial. The authors noted continued improvement at mean follow-up intervals ranging from 1.5 years to 3.6 years after surgery.

The American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) published a white paper on functional blepharoplasty, blepharoptosis, and brow ptosis repair (2015). They recommend blepharoplasty when peripheral visual field testing performed with the eyelid and brow in the resting position documents a baseline superior visual field of 30 degrees or less from fixation and improvement of at least 12 degrees over baseline with eyelid and brow elevation. They further state unobstructed, the superior field normally measures approximately 45 to 50 degrees. An MRD of 2 mm corresponds to a superior visual field impairment of 12-15 degrees. Thus, a baseline superior visual field of 30-35 degrees corresponds to an MRD of 2mm. A superior visual field of 30 degrees or less that improves with eyelid and brow elevation corresponds to a functional superior visual field loss.

The American Society of Plastic Surgeons (ASPS) published a practice parameter for blepharoplasty in 2007. They state blepharoplasty is performed for both functional and aesthetic reasons. Functional issues include ptosis, floppy eyelid syndrome, blepharochalasis, dermatochalasis, herniated orbital fat, and visual field obstruction. Aesthetic reasons include a desire for a more youthful or less fatigued appearance. Preoperative consultation should evaluate the patient's reasons for seeking surgery. The physical examination should include an evaluation of the amount of skin on the upper and lower lids; distribution of orbital fat; vector of the lower eyelid; and physical characteristics of the skin including degree of elasticity and pigmentation. Ptosis of the upper eyelid is determined by measuring the palpebral fissure width and margin reflex distance. Levator excursion is also assessed. The forehead and eyebrow should be evaluated for brow ptosis. Preoperative photographs may be taken to meet the requirements of both the insurers and surgeons. Additional photographs may include upward and downward gaze as well as oblique views. Visual field assessment is required for functional blepharoplasty. Consultation with an optometrist or ophthalmologist may be arranged for field of vision examination. When there are visual field impairment blepharoplasty procedures are considered to be reconstructive. However, blepharoplasty procedures are most often performed to enhance appearance.

The American Society of Plastic Surgeons Evidence published evidenced based clinical practice guidelines regarding eyelid surgery for upper visual field improvement (Kim 2022). A group of experts from different disciplines was convened to develop guidelines for the management of upper visual field impairments related to eyelid ptosis and dermatochalasis. The goal was to provide evidence-based recommendations to improve patient care. A systematic literature review was performed including topics regarding documentation of the underlying cause for visual field impairment, selection of an appropriate surgical repair, assessment of the type of anesthesia, the use of adjunctive brow procedures, and follow-up assessments. The review of the literature revealed varied complication rates and diverse treatment modalities for the correction of upper visual field deficit. Strong recommendations could not be made in most topic areas because of a paucity of methodologically sound studies in literature. More rigorously designed studies are needed to measure

outcomes of interest, with fewer sources of potential error or bias. The workgroup recommends that for patients presenting with low upper eyelid position, clinicians obtain a clinical history, which should include an assessment of impact on visual field or activities of daily living; and perform a physical examination to assess upper eyelid position (ptosis) relative to the pupil (such as MRD-1) with photographic documentation and assessment of levator function (Level of evidence weak, moderate recommendation).

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

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)

Code	Description
67909	Reduction of overcorrection of ptosis
67999	Unlisted procedure, eyelids

HCPCS Codes

Code	Description
Not Applicable	

ICD10 Codes

Code	Description
Multiple Codes	

REFERENCES

American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). White paper on functional blepharoplasty, blepharoptosis, and brow ptosis repair. 2015 Jan.

American Society of Plastic Surgeons [Internet]. Practice parameter for blepharoplasty, 2007 Mar [accessed 2026 Feb 2]. Available from: http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/evidence-practice/Blepharoplasty-Practice-Parameter.pdf

Cahill KV, et al. Functional indications for upper eyelid ptosis and blepharoplasty surgery: a report by the American Academy of Ophthalmology. Ophthalmology. 2011 Dec;118(12):2510-7.

Eid L and Tsirbas A. Subbrow blepharoplasty in Caucasians. Plast Reconstr Surg. 2021;147(3):604-607.

Hollander MHJ, et al. Functional outcomes of upper eyelid blepharoplasty: A systematic review. J Plast Reconstr Aesthet Surg. 2019 Feb;72(2):294-309.

Kim KK, et al. American Society of Plastic Surgeons evidence-based clinical practice guideline: eyelid surgery for upper visual field improvement. Plast Reconstr Surg. 2022 Aug 1;150(2):419e-434e.

Rodrigues C, et al. Upper eyelid blepharoplasty: surgical techniques and results-systematic review and meta-analysis. Aesthetic Plast Surg. 2023 Oct;47(5):1870-1883.

Stein MJ, et al. Practice patterns in blepharoplasty: a 15-year review of continuous certification tracer data from the American Board of Plastic Surgery. Plast Reconstr Surg. 2025 May 1;155(5):895-901.

Ulas B, et al. Evaluation of visual field and ocular surface parameters by clinical comparison after blepharoplasty for dermatochalasis. J Fr Ophthalmol. 2024 Apr;47(4):104135.

Vagefi MR, et al. Health-related quality-of-life outcomes for upper blepharoplasty and blepharoptosis surgery: a report by the American Academy of Ophthalmology. Ophthalmology. 2025 Dec;132(12):1445-1456.

SEARCH TERMS

Transconjunctival blepharoplasty, Transcutaneous blepharoplasty

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Blepharoplasty is not addressed in National or Regional Medicare coverage determinations or policies.
Blepharoplasty – (Medical Policy Article A52837) [accessed 2026 Feb 2]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

06/27/02, 07/24/03, 08/26/04, 06/23/05, 04/27/06, 02/22/07, 12/13/07, 10/23/08, 12/11/08, 02/26/09, 02/25/10, 02/24/11, 06/28/12, 02/28/13, 04/24/14, 04/23/15, 04/28/16, 06/22/17, 04/26/18, 04/25/19, 04/23/20, 04/22/21, 04/21/22, 03/23/23, 03/21/24, 03/20/25, 03/19/26

Date	Summary of Changes
03/19/26	• Annual review, policy intent unchanged.
03/20/25	• Annual review, title change, revision to visual field-testing criteria, degree of improvement changed from 20 to 12.
01/01/25	• Summary of changes tracking implemented.
06/27/02	• Original effective date