All patients must have a detailed written or transcribed history and note on the chart prior to performing any procedure, detailing the need for blepharoplasty.

**Diagnosis:**

<table>
<thead>
<tr>
<th>Confirmed by:</th>
<th>Documented patient signs/symptoms</th>
<th>Visual field testing</th>
<th>Marginal Reflex Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documentation of clinically decreased vision</td>
<td>Lateral and full face photographs</td>
<td>H&amp;P</td>
</tr>
</tbody>
</table>

**Procedure:** Blepharoplasty

Blepharoplasty may be considered medically necessary to correct FUNCTIONAL VISUAL IMPAIRMENT or CHRONIC DERMATITIS DUE TO REDUNDANT SKIN. The criteria in section A (patient signs and symptoms), section B (photographs), and section C (visual field) below must be documented to demonstrate medical necessity:

1. Documentation in the medical records must include patient complaints and findings secondary to eyelid or brow malposition such as:
   - Interference with vision or visual field, related to activities such as, difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue.
   - Chronic eyelid dermatitis due to redundant skin.
   - Difficulty wearing prosthesis, artificial eye.
   - Margin reflex distance (MRD) of 2.5 mm or less. (The margin reflex distance is a measurement from the corneal light reflex to the upper eyelid margin with the brows relaxed.)
   - A palpebral fissure height on down-gaze of 1 mm or less. (The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated.)

2. The presence of Herring’s effect meeting one of the above two (#4 or 5) criteria. (Herring’s law is one of equal innervation to both upper eyelids and is considered in the documentation to perform bilateral ptosis in which the of one upper eyelid has marginal criteria and the other eyelid has good supportive documentation for ptosis surgery. In these cases, the surgeon can lift the more ptotic lid with tape or instillation of Phenylephrine drops into the superior fornix. If the less ptotic lid then drops downward according to Herring’s law to the point of an MRD of 2.5 mm or less or a down-gaze MRD of 1.5 or less or a palpebral fissure width on down-gaze of 1 mm or less, then the less ptotic lid would be considered for surgical correction.)

3. Photographs and medical record documentation must demonstrate at least one of the following:
   - For Blepharoptosis Repair: Photographs of both eyelids in the frontal, straightahead position and/or down-gaze should be taken as appropriate.
   - For Blepharoplasty Repair: Frontal photos are needed to demonstrate redundant skin on the upper eyelids.
     - Upper eyelid skin resting on the eyelashes or over eyelid margin
     - Upper eyelid dermatitis secondary to redundant skin
     - Dermatochalasis
   - For Brow Ptosis Repair: Photographs should document medical necessity for brow ptosis repair (drooping of brows). Frontal photographs are necessary.
   - For a combination of any of the above procedures (blepharoptosis repair, blepharoplasty repair and brow ptosis repair): the medical necessity criteria for each procedure must be met and the additional criteria of lateral and full-face photographs with attempts at brow elevation and upward gaze (i.e., with the brow relaxed) must also be met.
BAPTIST OUTPATIENT SERVICES

BLEPHAROPLASTY INDICATIONS CLINICAL NOTES

☐ C. Visual fields

☐ 1. The indication for surgery is supported if a difference of 12º or more or 30% superior visual field difference is demonstrated between visual field testing before and after manual elevation of the eyelids.

☐ 2. Visually significant brow ptosis may be documented by visual field testing with the brow elevated demonstrating a difference of 12º or more or 30% superior visual field difference.

☐ 3. Visual fields need to meet accepted quality standards, whether they are performed by the Goldmann perimeter technique or by use of a standardized automated perimetry technique.

☐ 4. Visual fields are not necessary for patients with an anophthalmic socket who is experiencing ptosis of difficulty with their prosthesis.

☐ 5. For a combination of any of the above procedures (blepharoptosis repair, blepharoplasty repair and brow ptosis repair): the medical necessity criteria for each procedure must be met and the additional criteria of the visual field testing demonstrates visual impairment that cannot be addressed by one procedure alone, must also be met.

☐ D. Relief of eye symptoms associated with blepharospasm. Primary essential idiopathic blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated (i.e., an injection of Botulinum Toxin A,) an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary. (See Botulinum Toxin Type A and Type B, L34635)

*Note: Blepharoplasty for solely cosmetic purposes is not medically necessary.

Patient education: ________________________________________________________

________________________________________________________________________

Comments: _____________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Physician signature________________________________________________  Date______________

Print Name________________________________________________________ Time_____________

Source: Local Coverage Determination (LCD): Blepharoplasty, Blepharoptosis and Brow Lift (L34528)