KAISER PERMANENTE® Mid-Atlantic States	**Blepharoplasty, Entropion/Ectropion Repair, Repair for Corneal Exposure, Lid Ptosis and Brow Lift Surgery Medical Coverage Policy**

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.

I. Specialty: Plastic and Reconstructive Surgery, Vision Services

II. Diagnosis: Entropion, Ectropion and Ptosis (Eyelid)

III. Coverage

A. The functional goal of blepharoplasty is to improve a patient's visual function

B. Coverage for plastic and reconstructive surgery is contractually limited to those procedures that are intended to significantly improve physical function.

C. Procedures and services that improve or maintain appearance, and are not expected to significantly improve physical function, are considered cosmetic and are usually excluded contractually.

D. Inform your patient that certain plastic surgery procedures may not be covered benefits because of specific exclusions in their employer's contract with Kaiser Foundation Health Plan, Inc. (KFHP). Note that contracts may differ significantly for Maryland, Virginia, DC, Federal, Medicare, and for self-pay members.

E. Imaging and testing necessary to establish a diagnosis are covered benefits, as long as they are ordered by a Kaiser Permanente-participating physician. If your patient has questions about their plastic and reconstructive surgery benefit, direct them to inquire with Member Services.

IV. Criteria for the Upper Eyelid

Surgery of the upper eyelid is considered medically necessary for any ONE of the following:

A. Congenital defect (e.g., ptosis, coloboma), interfering with vision, as indicated by upper lid margin below the upper pupil border *AND* superior visual field defect within 30 degrees of fixation by perimetry. N.B. Visual fields are NOT required in children aged 13 or under;

B. To repair defects predisposing to corneal or conjunctival irritation:
1. Entropion when local measures fail to control symptoms and corneal abrasion or eye pain are present;
2. Ectropion when local measures fail to control symptoms;
3. Pseudotriachiasis; or
4. Corneal exposure

C. Periorbital sequelae of thyroid disease or nerve palsy;

D. Ptosis of lid interfering with vision, as indicated by upper lid margin below the upper pupil border *AND* reversible superior visual field defect within 30 degrees of fixation by perimetry;

E. Redundancy of upper eyelid skin (dermatochalasis) interfering with vision, as indicated by *EITHER* peripheral visual field impairment within 30 degrees of fixation by perimetry *OR* upper visual field improvement ≥20 degrees with taped lid;

F. Secondary eyelid repair (e.g., due to trauma or keloid formation);

G. Tumor or suspicious mass on the lid skin and/or margin;

H. To relieve painful symptoms of blepharospasm that is refractory to medical management (i.e. botulinum toxin injections);

I. To correct prosthesis difficulties in an anopthalmic socket;

J. Brow lift to repair ptosis or to repair laxity of the forehead muscles causing functional visual impairment as documented by both of the following;
1. Upper lid margin below the upper pupil border *AND* superior visual field defect within 30 degrees of fixation by perimetry; and
2. Clinical documentation that the eyebrow is below the supraorbital rim.

V. Criteria for the Lower Eyelid

Surgery of the lower eyelid is indicated for any ONE of the following:

A. To repair defects predisposing to corneal or conjunctival irritation:
1. Entropion;
2. Ectropion;
3. Pseudotriachiasis; or
4. Corneal exposure

B. Secondary eyelid repair (e.g., s/p trauma or keloid formation); or

C. Tumor or suspicious mass on the lid skin and/or margin.

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Approval History

Date approved by RUMC*	Date filed with the State of Maryland	Date of Implementation (Ten days after filing)
04/14/2011	04/15/2011	04/26/2011
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04/26/2016	04/28/2016	05/11/2016

*The Regional Utilization Management Committee received ***delegated authority*** from the Regional Quality Improvement Committee to review and approve designated Utilization Management and Medical Coverage Policies in 2011.

Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
04/25/2017	04/26/2017
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*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Whenever possible, Medical Coverage Policies are evidence-based and may also include expert opinion. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.