

**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.**

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**NC Medicaid  
Blepharoplasty/Blepharoptosis  
(Eyelid Repair)**

**Medicaid  
Clinical Coverage Policy No: 1A-9  
Amended Date: August 15, 2023**

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## 1.0 Description of the Procedure, Product, or Service

Blepharoplasty and blepharoptosis eyelid repair are reconstructive plastic surgery procedures of the eyelids. Surgery of the upper eyelids is reconstructive when it provides functional vision or visual field benefits or improves the functioning of a malformed or degenerated body member. The goal of reconstructive surgery is to restore function to the eye structure.

### 1.1 Definitions

#### **Blepharoplasty**

Blepharoplasty is the plastic repair of the eyelid in which redundant skin, muscle, or fat are excised. Functional blepharoplasty involves the excision of skin and orbicularis muscle. This procedure is performed to correct a deficit in the upper or peripheral field of vision or as noted on forward gaze by skin resting on the upper eyelashes.

#### **Blepharoptosis**

Blepharoptosis is drooping of the upper eyelid caused by a weakness of the muscles. The condition is congenital or acquired and can cause significant functional visual impairment. Blepharoptosis repair is performed to repair dysfunctioning eyelid muscles (e.g., levator or Muller's) in order to correct visual field deficit.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term "General" found throughout this policy applies to all Medicaid policies)*

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*;
- b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

#### 2.1.2 Specific

*(The term "Specific" found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.

## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

#### a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

#### b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing*

*Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*  
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

### 3.0 When the Procedure, Product, or Service Is Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

#### 3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

#### 3.2 Specific Criteria Covered

##### 3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover Blepharoplasty and blepharoptosis eyelid repair when the following medical necessity criteria are met:

- a. Ptosis obstructs vision to less than 30 degrees on the vertical meridian, **OR**
- b. The beneficiary has exposure keratitis.

**Note:** Eyelid repair for any other medical reason will be considered on a case-by-case basis.

##### 3.2.2 Medicaid Additional Criteria Covered

None Apply.

### 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

#### 4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or

- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

## 4.2 Specific Criteria Not Covered

### 4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover blepharoplasty and blepharoptosis eyelid repair when the medical criteria listed in **Section 3.0** is not met. Medicaid shall not cover blepharoplasty and blepharoptosis eyelid repair performed solely for cosmetic reasons to enhance aesthetic appearance.

### 4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### 5.1 Prior Approval

Medicaid shall require prior approval for blepharoplasty and blepharoptosis eyelid repair. The provider shall obtain prior approval before rendering blepharoplasty and blepharoptosis eyelid repair.

### 5.2 Prior Approval Requirements

#### 5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2.1** of this policy.

#### 5.2.2 Specific

In addition to the general requirements found in **Subsection 5.2.1**, providers are also required to submit the following:

- a. medical documentation that the eyelid ptosis obstructs vision including visual field examination results, unless the beneficiary is unable to test; **OR**
- b. medical documentation that the beneficiary has exposure keratitis of the lower eyelid; **OR**
- c. medical documentation to substantiate medical necessity for surgery including the following:
  - 1. beneficiary complaints of interference with vision or visual fields, difficulty reading due to eyelid drooping, looking through eyelashes, or seeing upper eyelid skin;
  - 2. relevant medical history;
  - 3. physical examination findings; and

4. results of pertinent diagnostic tests or procedures.

### **5.3 Additional Limitations or Requirements**

None Apply.

## **6.0 Providers Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

None Apply.

### **6.2 Provider Certifications**

None Apply.

## **7.0 Additional Requirements**

***Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.***

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## 8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1986

### Revision Information:

Date	Section Updated	Change
12/01/03	Section 3.0	This section was reformatted; there was no change to the content.
12/01/03	Section 4.0	The sentence “Blepharoplasty/blepharoptosis eyelid repair is not covered when the medical criteria listed in Section 3.0 are not met.” was added to this section.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/03	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/03	Section 8.3	The statement in Section 8.4 regarding CPT codes that are subject to multiple surgery guidelines was incorporated into Section 8.3.
12/01/03	Section 8.5	Section 8.5 was renumbered to Section 8.4.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/1/05	Section 2.2	The web address for DMA’s EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 4	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
7/1/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, <b>Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”</b>
3/12/12	Sections 1.0, 2.0, 3.0, 4.0, 5.0, 6.0,.7.0	Updated standard DMA policy template language
3/12/12	Section 8.0	Moved to Attachment A: Claims Related Information
3/12/12	Section 9.0	Moved to Section 8.0
3/12/12	Section 1.0	Added description of blepharoplasty and blepharoptosis
3/12/12	Subsection 5.2	Updated prior approval requirements
3/12/12	Attachment A	Added descriptions of diagnosis codes and procedure codes
3/12/12	Throughout	To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 1A-9 under Session Law 2011-145.
3/1/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.



<b>Date</b>	<b>Section Updated</b>	<b>Change</b>
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
04/01/2018	Subsection 4.2	Wording changed to replace text inadvertently removed during the amendment process.
04/01/2018	Subsection 5.2.2	Text moved from 5.2.1 to 5.2.2 to comply with policy format.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/04/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/04/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
8/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 8/15/2023 with an effective date of 4/1/2023.

### Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

#### A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

#### B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Providers Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10- Code(s)			
H02.30	H02.403	H02.429	H02.835
H02.31	H02.409	H02.431	H02.836
H02.32	H02.411	H02.432	H02.839
H02.33	H02.412	H02.433	H16.211
H02.34	H02.413	H02.439	H16.212
H02.35	H02.419	H02.831	H16.213
H02.36	H02.421	H02.832	H16.219
H02.401	H02.422	H02.833	Q10.0
H02.402	H02.423	H02.834	

#### C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s)	
15820	67903
15821	67904
15822	67906
15823	67908
67901	67909
67902	67911

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Providers(s) shall report the appropriate code(s) used which determines the billing unit(s).

**F. Place of Service**

Inpatient, Outpatient, Office.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

**H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>