Clinical Policy: Eyelid Reanimation

Reference Number: OC.UM.CP.0078
Last Review Date: 11/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Facial paralysis can result in keratopathy secondary to corneal exposure and inadequate lacrimation. This policy describes the medical necessity requirements for eyelid reanimation.

Policy/Criteria

I. It is the policy of health plans affiliated with Envolve Vision, Inc.® (Envolve) that eyelid reanimation is **medically necessary** when both of the following criteria are met:
   A. Lagophthalmos;
   B. Failed conservative treatment (e.g., corneal lubricants, moisture chambers, taping).

Background

One of the major sequelae of facial nerve palsy is lagophthalmos, or the inability to close the eye completely due to decreased action of the orbicularis oculi muscle. Lagophthalmos places the eye at risk and protection and lubrication of the eye is paramount in the management of these patients. If recovery of facial function is likely to be delayed or negligible, gold weight loading of the upper lid has been shown to be effective in providing a dynamic solution to lagophthalmos. The weights have been shown to decrease corneal exposure, decrease reliance on artificial teardrops, and increase patient comfort. The implant is easily removed from those patients who, having undergone early implantation, eventually recover adequate function, and in patients who are not able to tolerate the gold implant. Albeit effective, the insertion of weighted gold implants at the upper eyelid carries with it several potential complications including infection (8%), allergic reaction to gold (1%), visibility of the implant underneath the skin (31%), migration of the implant within the eyelid (2.6%), extrusion (43%), residual lagophthalmos (30%), or ptosis (12%). If a different physician must remove the infected gold implant, procedure code 67938 may be reported. If the area becomes infected and needs to be removed by the same physician who initially inserted the gold implant, procedure code 67999 may be reported.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)
67938	Removal of embedded foreign body, eyelid

CPT® Codes	Description
67999	Unlisted procedure, eyelids

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
H02.211	Cicatricial lagophthalmos right upper eyelid
H02.212	Cicatricial lagophthalmos right lower eyelid
H02.214	Cicatricial lagophthalmos left upper eyelid
H02.215	Cicatricial lagophthalmos left lower eyelid
H02.21A	Cicatricial lagophthalmos right eye, upper and lower eyelids
H02.21B	Cicatricial lagophthalmos left eye, upper and lower eyelids
H02.21C	Cicatricial lagophthalmos, bilateral, upper and lower eyelids
H02.221	Mechanical lagophthalmos right upper eyelid
H02.222	Mechanical lagophthalmos right lower eyelid
H02.224	Mechanical lagophthalmos left upper eyelid
H02.225	Mechanical lagophthalmos left lower eyelid
H02.22A	Mechanical lagophthalmos right eye, upper and lower eyelids
H02.22B	Mechanical lagophthalmos left eye, upper and lower eyelids
H02.22C	Mechanical lagophthalmos, bilateral, upper and lower eyelids
H02.231	Paralytic lagophthalmos right upper eyelid
H02.232	Paralytic lagophthalmos right lower eyelid
H02.234	Paralytic lagophthalmos left upper eyelid
H02.235	Paralytic lagophthalmos left lower eyelid
H02.23A	Paralytic lagophthalmos right eye, upper and lower eyelids
H02.23B	Paralytic lagophthalmos left eye, upper and lower eyelids
H02.23C	Paralytic lagophthalmos, bilateral, upper and lower eyelids

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template	08/2020	10/2020
Annual Review	12/2020	12/2020
Annual Review	12/2021	12/2021
Annual Review	11/2022	11/2022

References
1. Sansone V, Boynton J, Palenski C. Use of gold weights to correct lagophthalmos in neuromuscular disease. Neurology. 1997;48(6):1500 1503.
2. Gendy A, Therattil PJ. Postseptal Weight Placement for Paralytic Lagophthalmos. Eplasty. 2016; 16: ic26.
3. Seiff SR. Treatment of facial palsies with external eyelid weights. Am J Ophthalmol. 1995;120(5):652-657.
4. Kartush JM, Linstrom CJ, McCann PM, et al. Early gold weight eyelid implantation for facial paralysis. Otolaryngol Head Neck Surg. 1990;103:1016-1023.
5. O'Connell JE, Robin PE. Eyelid gold weights in the management of facial palsy. J Laryngol Otol. 1991;105:471–4.
6. Lavy JA, East CA, Bamber A, Andrews PJ. Gold weight implants in the management of lagophthalmos in facial palsy. Clin Otolaryngol. 2004;29 (3):279-283.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Vision, Inc., or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment

for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.