Priority Health	BILLING POLICY No. 102
BLEPHAROPLASTY, BLEPHAROPTOSIS & BROW LIFT	
Effective date: Aug. 25, 2025 **Date of origin: June 24, 2025**	**Review dates: 2/2026**

DEFINITION
Blepharoplasty (eyelid surgery), blepharoptosis (drooping eyelid) repair and brow lift payments vary among payers and are contingent upon functional impairment.

MEDICAL POLICY

- Cosmetic and Reconstructive Surgery Procedures (#91535)

POLICY SPECIFIC INFORMATION
Code ranges

- 15820 – 15823
- 67900 – 67908

Blepharoptosis repair (CPT 67904) followed by blepharoplasty (CPT 15823) on the same eye in a separate procedure within 12 months is not separately payable.

Modifiers
These are unilateral procedures. If performed bilaterally, the service may be reported once with modifier 50 or two lines of the service with the RT and LT modifiers.

Medicare global surgery and Correct Coding Initiative (CCI) rules are applicable to these procedures.

Get information about non-standard cost-sharing in our Provider Manual.

REFERENCES

- Article – Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908) (CMS)
- Provider Manual – Blepharoplasty (Priority Health)

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require

industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
2/2026	Reviewed- No Updates