

Clinical Policy: Adjacent Tissue Transfer / Grafts involving Eyelid

Reference Number: CP.VP.01

Last Review Date: 01/2022

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description:

Adjacent tissue transfer/grafts involves transferring or rearranging adjacent tissue or performing a full thickness graft to repair traumatic or surgical wounds on the forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, feet nose, ears, eyelids and/or lips. This policy describes the medical necessity requirements for adjacent tissue transfers or grafts involving the eyelids.

Policy/Criteria

- I. It is the policy of health plans associated with Centene Corporation[®] (Centene) that adjacent tissue transfer and full thickness grafts are **medically necessary** for the following indications:
 - A. Ectropion (out-turning of the eyelid) presenting with keratoconjunctivopathy, infection, dermatitis, or other related symptoms. Tearing is a common presentation, whether the punctum is everted (resulting in a tear outflow problem) or not (as in reflex tearing from irritation and exposure keratoconjunctivopathy). Combined-mechanism tearing is not unusual in these cases.
 - B. Entropion (in-turning of the eyelid) presenting with an irritated eye with foreign-body sensation caused by inwardly rotated eyelashes and eyelid skin. The eye is red from keratoconjunctivopathy.

Background:

Entropion is a condition in which the eyelid margin turns inwards against the globe. It is divided into following categories: congenital and acquired, which may be involuntal or cicatricial. Ectropion is a malposition in which the lid falls away or is pulled away from its normal apposition to the globe. The condition is classified as congenital and acquired, which is divided into following categories: involuntal, cicatricial, paralytic, and mechanical. Therefore, there are some common anatomic changes for both entropion and ectropion as well as specific changes that are unique to each eyelid malposition. Typically, instability of the eyelid is caused by either horizontal laxity or disinsertion or attenuation of the lower eyelid retractors to the inferior tarsal border, so surgical procedures should be directed at correcting the horizontal and vertical instability of the lid. Most involuntal ectropion/entropion repairs may be accomplished with horizontal lid shortening/full thickness wedge resection/lateral canthoplasty repairs (CPT 67917 or 67924).

Full thickness skin grafts are a viable option for the majority of patients with cicatricial lower eyelid ectropion, showing strong graft viability, improvement in the degree of ectropion, a decrease in dependence on topical lubricants and improvement of ocular surface damage and symptoms

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CPT® Codes	Description
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and / or feet; defect 10 sq. cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq. cm to 30.0 sq. cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq. cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq. cm to 30.0 sq. cm
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq. cm or less
15261	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq. cm, or part thereof (List separately in addition to code for primary procedure)
67917	Repair of ectropion, extensive (e.g., tarsal strip operations)
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalpebral fascia repairs operation)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
G51.0	Bell's palsy
H02.001	Unspecified entropion of right upper eyelid
H02.002	Unspecified entropion of right lower eyelid
H02.004	Unspecified entropion of left upper eyelid
H02.005	Unspecified entropion of left lower eyelid
H02.011	Cicatricial entropion of right upper eyelid
H02.012	Cicatricial entropion of right lower eyelid
H02.014	Cicatricial entropion of left upper eyelid
H02.015	Cicatricial entropion of left lower eyelid
H02.021	Mechanical entropion of right upper eyelid
H02.022	Mechanical entropion of right lower eyelid
H02.024	Mechanical entropion of left upper eyelid
H02.025	Mechanical entropion of left lower eyelid

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ICD-10-CM Code	Description
H02.031	Senile entropion of right upper eyelid
H02.032	Senile entropion of right lower eyelid
H02.034	Senile entropion of left upper eyelid
H02.035	Senile entropion of left lower eyelid
H02.041	Spastic entropion of right upper eyelid
H02.042	Spastic entropion of right lower eyelid
H02.044	Spastic entropion of left upper eyelid
H02.045	Spastic entropion of left lower eyelid
H02.101	Unspecified ectropion of right upper eyelid
H02.102	Unspecified ectropion of right lower eyelid
H02.104	Unspecified ectropion of left upper eyelid
H02.105	Unspecified ectropion of left lower eyelid
H02.111	Cicatricial ectropion of right upper eyelid
H02.112	Cicatricial ectropion of right lower eyelid
H02.114	Cicatricial ectropion of left upper eyelid
H02.115	Cicatricial ectropion of left lower eyelid
H02.121	Mechanical ectropion of right upper eyelid
H02.122	Mechanical ectropion of right lower eyelid
H02.124	Mechanical ectropion of left upper eyelid
H02.125	Mechanical ectropion of left lower eyelid
H02.131	Senile ectropion of right upper eyelid
H02.132	Senile ectropion of right lower eyelid
H02.134	Senile ectropion of left upper eyelid
H02.135	Senile ectropion of left lower eyelid
H02.141	Spastic ectropion of right upper eyelid
H02.142	Spastic ectropion of right lower eyelid
H02.144	Spastic ectropion of left upper eyelid
H02.145	Spastic ectropion of left lower eyelid
H02.151	Paralytic ectropion of right upper eyelid
H02.152	Paralytic ectropion of right lower eyelid
H02.154	Paralytic ectropion of left upper eyelid
H02.155	Paralytic ectropion of left lower eyelid
H02.201	Unspecified lagophthalmos right upper eyelid
H02.202	Unspecified lagophthalmos right lower eyelid
H02.204	Unspecified lagophthalmos left upper eyelid
H02.205	Unspecified lagophthalmos left lower eyelid
H02.20A	Unspecified lagophthalmos right eye, upper and lower eyelids
H02.20B	Unspecified lagophthalmos left eye, upper and lower eyelids
H02.20C	Unspecified lagophthalmos, bilateral, upper and lower eyelids
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

Adjacent Tissue Transfer / Grafts involving Eyelid

ICD-10-CM Code	Description
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
H05.331	Deformity of right orbit due to trauma or surgery
H05.332	Deformity of left orbit due to trauma or surgery
H05.333	Deformity of bilateral orbits due to trauma or surgery

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	12/2019	12/2019
Converted to new template	04/2020	06/2020
Annual Review; Revised background; Updated references	12/2020	12/2020
Annual Review	12/2021	01/2022

References

1. Quickert MH, Rathbun E. Suture repair of entropion. *Arch Ophthalmol*. 1971 Mar. 85(3):304-5.
2. Burroughs JR, Soparkar CN, Patrinely JR. Rotation mattress suture: a powerful adjunct for ectropion correction. *Ophthal Plast Reconstr Surg*. 2003 Sep. 19(5):404-6. [Medline].
3. Nowinski TS, Anderson RL. The medial spindle procedure for involutional medial ectropion. *Arch Ophthalmol*. 1985 Nov. 103(11):1750-3.
4. Kim HJ, Hayek B, Nasser Q, Esmali B. Viability of full-thickness skin grafts used for correction of cicatricial ectropion of lower eyelid in previously irradiated field in the periocular region. *Head Neck*. 2013;35(1):103-108.
5. Piskiniene R. Eyelid malposition: lower lid entropion and ectropion. *Medicina (Kaunas)*. 2006;42(11):881-4. PMID: 17172788.

CLINICAL POLICY**Adjacent Tissue Transfer / Grafts involving Eyelid****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 Centene Management Company, LLC, 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.

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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.

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