Medical Necessity Guidelines:
Blepharoplasty, Upper/Lower Eyelid, and Brow and/or Eyelid Ptosis Repair

Effective: January 1, 2024

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.

| Yes ☒ | No ☐ |

Notification Required
IF REQUIRED, concurrent review may apply

| Yes ☐ | No ☒ |

Applies to:

**Commercial Products**
- Harvard Pilgrim Health Care Commercial products; 800-232-0816
- Tufts Health Plan Commercial products; 617-972-9409
  - CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Public Plans Products**
- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
- Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
- Tufts Health One Care – A dual-eligible product; 857-304-6304

**Senior Products**
- Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
- Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
- Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:
This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:
- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

For Tufts Health Plan Members:
To obtain InterQual® SmartSheets™:
- **Tufts Health Plan Commercial Plan products**: If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products**: InterQual® SmartSheet(s) available as part of the prior authorization process
Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization. In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan Clinical Guideline Coverage Criteria.

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan Members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For Tuft's Health One Care plan Members, the following criteria is used: LCD - Blepharoplasty, Blepharoptosis and Brow Lift (L34528) (cms.gov) and Article - Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908) (cms.gov).

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for brow ptosis, blepharoplasty, and blepharoptosis:
1. Brow Ptosis Repair
2. Blepharoplasty, Upper Eyelid
3. Blepharoplasty, Lower Eyelid

Plan Modification to InterQual:
1. Blepharoplasty Upper Eyelid
   a. Section 30: Upper eyelid dermatochalasis
      i. Criteria 2.A: Upper eyelid margin reflex distance (MRD) ≤ 2.5 mm from mid-pupil in primary gaze
         skin overhangs upper eyelid margin
      ii. Criterion 2.B: Superior visual field loss ≥ 12 degrees or 30% and skin overhangs upper eyelid margin

In Addition, The Plan requires the following criteria:

Upper Eyelid Blepharoptosis Repair
The Plan considers upper eyelid blepharoptosis repair as reasonable and medically necessary when documentation confirms the ONE of the following:
1. **ONE** of the following criteria is met:
   a. Prosthesis difficulties, including ptosis, in an anophthalmic socket; or
   b. Margin reflex distance (MRD) of 2.5 mm or less; OR
   c. Defects (e.g., corneal exposure, ectropion, entropion, pseudotrichiasis) that predispose the member to
      corneal or conjunctival irritation; OR
   d. Painful symptoms of blepharospasm (e.g. excessive blinking, uncontrollable contractions or twitching of
      eye muscles, sensitivity to bright light); OR
   e. Peri-orbital sequelae of thyroid disease and nerve palsy;

2. **ALL** of the following criteria are met:
   a. **ONE** of the following criteria is met:
      i. Member has complaints of interference with daily visual tasks or visual field-related activities; OR
      ii. Member experiences visual obstruction due to excessive overhanging skin resting on or depressing
         the lashes or eyelid margin
   b. Visual field testing confirms **ALL** the following
      i. Eyelid at rest limits the upper visual field to less than 30 degrees (measured from the central fixation
         point); and
      ii. Redundant eyelid tissue and/or the upper eyelid taped with eyelid margin in an anatomically correct
         position demonstrates at least 12 degree or 30% improvement in the visual field defect; and
      iii. Visual fields need to meet accepted quality standards, whether they are performed by the
          Goldmann perimeter technique or by use of a standardized automated perimetry technique

Codes
The following code(s) require prior authorization:

### Table 1: CPT/HCPCS Codes – Brow Ptosis Repair

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
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</tbody>
</table>

### Table 2: CPT/HCPCS Codes – Upper Eyelid Blepharoptosis Repair

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>67901</td>
<td>Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)</td>
</tr>
<tr>
<td>67902</td>
<td>Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach</td>
</tr>
<tr>
<td>67904</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, external approach</td>
</tr>
<tr>
<td>67906</td>
<td>Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)</td>
</tr>
<tr>
<td>67908</td>
<td>Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)</td>
</tr>
</tbody>
</table>

### Table 3: CPT/HCPCS Codes – Blepharoplasty, Upper Eyelid

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15822</td>
<td>Blepharoplasty, upper eyelid</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty, upper eyelid: with excessive skin weighting down lid</td>
</tr>
</tbody>
</table>

### Table 4: CPT/HCPCS Codes – Blepharoplasty, Lower Eyelid

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15820</td>
<td>Blepharoplasty, lower eyelid</td>
</tr>
<tr>
<td>15821</td>
<td>Blepharoplasty, lower eyelid: with extensive herniated fat pad</td>
</tr>
</tbody>
</table>

References:

### Approval And Revision History
March 18, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:
- March 20, 2020: Unify fax number updated
- March 17, 2021: Reviewed by IMPAC, renewed without changes
- May 18, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan, effective September 1, 2022. CPT code 67909 will no longer require prior authorization. InterQual will no longer be used for eyelid ptosis repair. New criteria added for upper eyelid blepharoptosis repair. New modification to IQ for blepharoplasty upper eyelid subset
- April 19, 2023: Reviewed by MPAC, renewed without changes
- June 21, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024

### Background, Product and Disclaimer Information
Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis.
considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.