Medical Necessity Guidelines: Blepharoplasty of the Lower Eyelid

Effective: July 1, 2018

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

Applies to:
COMMERCIAL Products
☑ Tufts Health Plan Commercial products; Fax: 617.972.9409
☑ Tufts Health Freedom Plan products; Fax: 617.972.9409
• CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☑ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055
☑ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☑ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☑ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
This is a guideline for the medical necessity review of blepharoplasty of the lower eyelid. Blepharoplasty is a surgical procedure that can be performed on the upper or lower eyelid and includes the excision of redundant tissues (i.e., muscle, fat, skin) of the eyelids (MedlinePlus, 2007).

CLINICAL COVERAGE CRITERIA
Tufts Health Plan may authorize coverage for blepharoplasty of the lower eyelid when submitted clinical documentation confirms the Member meets ALL of the following criteria:
• Conjunctival or corneal irritation caused by one of the following:
  o Ectropion (i.e., eyelid turned outward)
  o Entropion (i.e., eyelid turned inward)
  o Trichiasis (i.e., inward misdirection of eyelashes caused by entropion)
• Failure of prescribed standard conservative treatment (e.g. lubricating eye drops, topical anti-inflammatory drugs, topical antibiotics, analgesics)

LIMITATIONS
Tufts Health Plan specifically excludes cosmetic surgery, which is surgery for the sole purpose of improving one’s appearance.

CODES
The following CPT codes require prior authorization:

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

APPROVAL HISTORY
March 5, 2007: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:
- May 28, 2008: Reviewed and renewed without changes
- June 1, 2009: Reviewed and renewed without changes
- May 2010: Reviewed at MSPAC, no changes
- June 8, 2011: Reviewed by MSPAC, approved by IMPAC, without changes
- July 10, 2013: Reviewed by IMPAC, renewed without changes
- June 11, 2014: Reviewed by IMPAC, renewed without changes
- May 13, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- May 11, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- May 10, 2017: Reviewed by IMPAC, renewed without changes
- February 14, 2018: Reviewed by IMPAC. Clarification that coverage is for conjunctival and/or corneal irritation. For effective date July 1, 2018, added criteria requires failure of prescribed standard conservative treatment.
- April 11, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated

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.

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.