Medical Necessity Guidelines: Blepharoplasty of the Lower Eye Lid

Effective: May 10, 2017

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Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
☒ Tufts Health Direct – Health Connector; Fax: 888.415.9055
☒ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

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 the 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).

COVERAGE GUIDELINES
Tufts Health Plan may authorize coverage for blepharoplasty of the lower eyelid if the Member meets one or more of the following criteria (documentation, including a letter of medical necessity, is required):

- Ectropion (i.e., eyelid turned outward)
- Entropion (i.e., eyelid turned inward)
- Trichiasis (i.e., inward misdirection of eyelashes caused by entropion)

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
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 the 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.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. 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. Applicable state or federal mandates or other requirements will take precedence. For CareLink℠ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines 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.