Medical Necessity Guidelines: Brow and/or Eyelid Ptosis Repair

Effective: May 10, 2017

|--------------------------------------------------------|---|------------------------------------------|

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

To obtain InterQual® SmartSheets™:

- **Tufts Health Plan Commercial Plan products and Tufts Health Freedom 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® SmartSheets™ available as part of the prior authorization process.

**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.

Tufts Health Plan requires prior authorization for repair of brow and/or eyelid ptosis repair.

In order to obtain prior authorization for procedure(s), choose appropriate InterQual SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number listed above, according to Plan.

- Ptosis Repair
- Blepharoplasty (for upper eyelid only)

**CODES**

**Procedures REQUIRING PRIOR AUTHORIZATION:**
Tufts Health Plan will be using InterQual SmartSheet(s) for the following procedure code(s) only.

**PTOSIS REPAIR**
The following CPT code(s) require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)</td>
</tr>
<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>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>
<tr>
<td>67909</td>
<td>Reduction of overcorrection of ptosis</td>
</tr>
</tbody>
</table>
**Note:** For the following CPT code(s), use the InterQual SmartSheet for **ptosis repair**:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67903</td>
<td>Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach</td>
</tr>
</tbody>
</table>

**BLEPHAROPLASTY (FOR UPPER EYELID ONLY)**

The following CPT code(s) require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
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</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>

**APPROVAL HISTORY**

March 5, 2007: Reviewed by the Medical Affairs Medical Policy Committee

Subsequent Endorsement Date(s) and Changes Made:

- April 7, 2008: Clarification of severity of ptosis calculations added.
- July 6, 2009: Use of photographs to demonstrate eyelid abnormalities allowed in some circumstances.
- May 2010: Reviewed at MSPAC, no changes.
- April 2011: Reviewed by MSPAC. Title changed to include “Eyelid”; definition of ptosis updated.
- November 1, 2011: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), the policy has been revised to add CPT codes 15822 and 15823 to the list of codes requiring prior authorization.
- August 8, 2012: Reviewed by IMPAC, renewed without changes.
- October 10, 2012: Reviewed by IMPAC. Completed InterQual® SmartSheets™ for these procedures will be required effective January 1, 2013.
- July 10, 2013: Reviewed by IMPAC, no changes.
- July 11, 2014: Reviewed by IMPAC, renewed without changes.
- January 1, 2015: Instructions for Tufts Health Plan – Network Health products included in this document.
- May 13, 2015: Reviewed by IMPAC, renewed without changes.
- September 21, 2015: Coding changes for effective date September 21, 2015, InterQual upgrade.
- 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.

**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.