Medical Necessity Guidelines: Brow and/or Eyelid Ptosis Repair

Effective: April 11, 2018

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

Yes ☒ No ☐

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

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 SmartSheet(s) 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>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------</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>
<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 weighing 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.
- June 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
- 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.