Blepharoplasty, Upper/Lower Eyelid and Brow and/or Eyelid Ptosis Repair

Authorization:
Prior authorization is required for all the following reconstructive eye procedures requested for members enrolled in commercial (HMO, POS, and PPO) products.

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 and/or color photographs 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)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Resources and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here.) Members may access these materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

Policy and Coverage Criteria:
For this policy, The Plan draws upon the following InterQual® criteria:
- Brow Ptosis Repair (Version 2022)
- Blepharoplasty, Lower Eyelid (Version 2022)

For this policy, The Plan draws upon the following InterQual® criteria, which has been customized:
- Blepharoplasty, Upper Eyelid (Version 2022)
- Upper Eyelid Blepharoptosis Repair (Version 2022)

In addition, HPHC requires the following criteria:

Upper Eyelid Blepharoptosis Repair
Harvard Pilgrim Health Care (HPHC) considers eyelid repair as reasonable and medically necessary when documentation confirms the following:
- Prosthesis difficulties in an anophthalmic socket, OR
- Margin reflex distance (MRD) of 2.5 mm or less, OR
- Defects (e.g., corneal exposure, entropion, entropion, pseudotrichiasis) that predispose the member to corneal or conjunctival irritation, OR
- Painful symptoms of blepharospasm (e.g. excessive blinking, uncontrollable contractions or twitching of eye muscles, sensitivity to bright light), OR
• Peri-orbital sequelae of thyroid disease and nerve palsy, OR
• Visual field obstruction when visual field testing confirms ALL the following:
  o Eyelid at rest limits the upper visual field to less than 30 degrees (measured from the central fixation point); AND
  o Redundant eyelid tissue and/or the upper eyelid taped with eyelid margin in an anatomically correct position demonstrates at least 12 degrees or 30% improvement in the visual field defect; AND
  o 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; AND
• Visual fields are not necessary for individuals with an anophthalmic socket who are experiencing ptosis of difficulty with their prosthesis.

Guidelines:
In accordance with MA Chapter 233 (An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment), HPHC covers treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome for any member enrolled in any HPHC plan delivered, issued or renewed within the commonwealth. Medical record documentation from a treating provider must confirm that the treatment is medically necessary for correcting, repairing or ameliorating the effects of HIV associated lipodystrophy syndrome.

Coding:
Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
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<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>
<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>
<tr>
<td>67900</td>
<td>Repair of brow ptosis (supraclial, 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>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>

Billing Guidelines:
Member’s medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

**References:**

4. CMS LCD L34528 Blepharoplasty, Blepharoptosis and Brow Lift

**Summary of Changes:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/22</td>
<td>Annual review; no changes</td>
</tr>
<tr>
<td>5/22</td>
<td>Criteria and coding updated for integration purposes with Tufts Health Plan (THP)</td>
</tr>
<tr>
<td>7/21</td>
<td>2021 InterQual® subsets adopted</td>
</tr>
<tr>
<td>2/21</td>
<td>Annual review; criteria updated</td>
</tr>
<tr>
<td>2/20</td>
<td>Criteria and coding updated</td>
</tr>
</tbody>
</table>

_HPHC Medical Policy_  

**Cosmetic and Reconstructive Eye Procedures**

*HPHC policies are based on medical science, and written to apply to the majority of people with a given condition. Individual members’ unique clinical circumstances, and capabilities of the local delivery system are considered when making individual UM determinations.*

Coverage described in this policy is standard under most HPHC plans. Specific benefits may vary by product and/or employer group. Please reference appropriate member materials (e.g., Benefit Handbook, Certificate of Coverage) for member-specific benefit information.
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InterQual® criteria adopted; criteria revised
Policy coverage criteria refined; background and references updated
Update to language to support mandate for HIV lipodystrophy
Minor formatting edits; updated exclusions
Add coding profile and reference.

Approved by Medical Policy Committee: 7/20/22
Policy Effective: 9/12/22
Initiated: 7/1/10