Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

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

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

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 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 Researched 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 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

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial 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

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

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

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan Members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For **Tuft's Health One Care** plan Members, the following criteria is used: LCD - Blepharoplasty, Blepharoptosis and Brow Lift (L34528) (cms.gov) and Article - Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908) (cms.gov)

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for brow ptosis, blepharoplasty, and blepharoptosis:

1. Brow Ptosis Repair
2. Blepharoplasty, Upper Eyelid
3. Blepharoplasty, Lower Eyelid

Plan Modification to InterQual:

1. Blepharoplasty Upper Eyelid
    a. Section 30: Upper eyelid dermatochalasis
        i. Criteria 2.A: Upper eyelid margin reflex distance (MRD) ≤ 2.5 mm from mid-pupil in primary gaze skin overhangs upper eyelid margin
        ii. Criterion 2.B: Superior visual field loss ≥ 12 degrees or 30% and skin overhangs upper eyelid margin

In Addition, The Plan requires the following criteria:

Upper Eyelid Blepharoptosis Repair

The Plan considers upper eyelid blepharoptosis repair as reasonable and medically necessary when documentation confirms the ONE of the following:

1. **ONE** of the following criteria is met:
    a. Prosthesis difficulties, including ptosis, in an anophthalmic socket; or
    b. Margin reflex distance (MRD) of 2.5 mm or less; OR
    c. Defects (e.g., corneal exposure, ectropion, entropion, pseudotrichiasis) that predispose the member to corneal or conjunctival irritation; OR
    d. Painful symptoms of blepharospasm (e.g. excessive blinking, uncontrollable contractions or twitching of eye muscles, sensitivity to bright light); OR
    e. Peri-orbital sequelae of thyroid disease and nerve palsy;
2. **ALL** of the following criteria are met:
    a. **ONE** of the following criteria is met:
        i. Member has complaints of interference with daily visual tasks or visual field-related activities; OR
        ii. Member experiences visual obstruction due to excessive overhanging skin resting on or depressing the lashes or eyelid margin
    b. Visual field testing confirms **ALL** the following
        i. Eyelid at rest limits the upper visual field to less than 30 degrees (measured from the central fixation point); **and**
        ii. Redundant eyelid tissue and/or the upper eyelid taped with eyelid margin in an anatomically correct position demonstrates at least 12 degree or 30% improvement in the visual field defect; **and**
        iii. 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

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes – Brow Ptosis Repair

Code	Description
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

Table 2: CPT/HCPCS Codes – Upper Eyelid Blepharoptosis Repair

Code	Description
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)

Table 3: CPT/HCPCS Codes – Blepharoplasty, Upper Eyelid

Code	Description
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid: with excessive skin weighting down lid

Table 4: CPT/HCPCS Codes – Blepharoplasty, Lower Eyelid

Code	Description
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad

References:

1. Centers for Medicare & Medicaid Service. Medical Policy Article A52837: Blepharoplasty. Accessed May 16, 2025.
2. Centers for Medicare & Medicaid Service. Local coverage determination (LCD) L34528: Blepharoplasty, Blepharoptosis and Brow Lift. Accessed January
3. Dashtipour K, et. al. Systematic Literature Review of AbobotulinumtoxinA in Clinical Trials for Blepharospasm and Hemifacial Spasm. Tremor Other Hyperkinet Mov (N Y). 2015 Oct 30;5:338. doi: 10.7916/D8CJ8CVR. PMID: 26566457; PMCID: PMC4636029.
4. Cahill KV, et. al. Functional indications for upper eyelid ptosis and blepharoplasty surgery: a report by the American Academy of Ophthalmology. Ophthalmology. 2011 Dec;118(12):2510-7. doi: 10.1016/j.ophtha.2011.09.029. Epub 2011 Oct 22. PMID: 22019388.

Approval And Revision History

March 18, 2020: Reviewed by IMPAC, renewed without changes

Subsequent endorsement date(s) and changes made:

- March 20, 2020: Unify fax number updated
- March 17, 2021: Reviewed by IMPAC, renewed without changes
- May 18, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan, effective September 1, 2022. CPT code 67909 will no longer require prior authorization. InterQual will no longer be used for eyelid ptosis repair. New criteria added for upper eyelid blepharoptosis repair. New modification to IQ for blepharoplasty upper eyelid subset
- April 19, 2023: Reviewed by MPAC, renewed without changes
- June 21, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Reviewed and approved by UM Committee effective January 1, 2024
- March 20, 2024: Reviewed by MPAC, renewed without changes effective May 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee, LCD links updated effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- March 19, 2025: Reviewed by MPAC, renewed without changes, effective April 11, 2025
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025
- March 12, 2026: Reviewed by MPAC, renewed without changes, references updated, effective May 1, 2026.

- March 12, 2026: Administrative update, template updated effective May 1, 2026.
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026.

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. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.