

Medical Necessity Guidelines: Cleft Lip and Cleft Palate: Massachusetts Products

Effective: October 21, 2020

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<p>Applies to: COMMERCIAL Products</p> <p><input checked="" type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409</p> <ul style="list-style-type: none"> CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>TUFTS HEALTH PUBLIC PLANS Products</p> <p><input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input checked="" type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</p> <p>SENIOR Products</p> <ul style="list-style-type: none"> 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 	

OVERVIEW

A cleft lip is a congenital deformity of the upper lip. A cleft palate is an opening in the roof of the mouth in which two sides of the palate did not join together. Cleft lips and palates can be unilateral or bilateral. The lip, nose and palate structures do not fuse correctly prior to birth as noted by a separation of the two sides of the lip. Often the deformity extends to the roof of the mouth (palate) and sometimes includes the bone of the upper jaw, which can result in problems with development of normal speech.

In accordance with Massachusetts General Law, Chapter 234 of the Acts of 2012, Tufts Health Plan Commercial Plans and Tufts Health Direct plan will cover the cost of treating cleft lip and cleft palate for Members until the Member's 18th birthday. In accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, Tufts Health Together plan will cover the cost of treating cleft lip and cleft palate for Members until the Member's 22nd birthday. Coverage includes medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventive and restorative dentistry, dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology and nutrition services when services are prescribed by the treating physician or surgeon and certified as medically necessary and consequent to the treatment of the cleft lip, cleft palate or both.

This coverage guideline is to be used for the following diagnosis codes only:

ICD-10-CM Codes

ICD-10 Code	Description
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q35.7	Cleft uvula
Q35.9	Cleft palate, unspecified
Q36.0	Cleft lip, bilateral
Q36.1	Cleft lip, median

ICD-10 Code	Description
Q36.9	Cleft lip, unilateral
Q37.0	Cleft hard palate with bilateral cleft lip
Q37.1	Cleft hard palate with unilateral cleft lip
Q37.2	Cleft soft palate with bilateral cleft lip
Q37.3	Cleft soft palate with unilateral cleft lip
Q37.4	Cleft hard and soft palate with bilateral cleft lip
Q37.5	Cleft hard and soft palate with unilateral cleft lip
Q37.8	Unspecified cleft palate with bilateral cleft lip
Q37.9	Unspecified cleft palate with unilateral cleft lip

This guideline provides information about whether a procedure requires prior authorization and how to obtain additional coverage information for dental and orthodontic services.

Please refer to the following Medical Necessity Guidelines for information regarding the coverage of these procedures/services which may require prior authorization:

- [Dental Procedures Requiring Hospitalization](#)
- [Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders](#)
- [Reconstructive and Cosmetic Surgery](#)
- Rhinoplasty
- Scar Revision
- Rehabilitative Services: Speech Therapy
- Habilitative Services for Physical Therapy, Occupational Therapy and Speech Therapy
- Outpatient Physical Therapy, Occupational Therapy and Speech Therapy

Please refer to the following list regarding coverage of other services.

- **Medical and facial surgery:** Covered as described under “day surgery”, “acute hospital services” and “reconstructive surgery and procedures” in the Evidence of Coverage. This includes surgical management and follow-up care by plastic surgeons
- **Oral surgery:** Covered as described under “oral health services” in the Evidence of Coverage. This includes surgical management and follow-up care by oral surgeons. No referral is necessary.
- **Dental surgery or orthodontic treatment and management:** No referral is necessary.
- **Preventive and restorative dentistry:** These services are covered to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy. No referral is necessary.
- **Speech therapy and audiology services:** Covered as described under “therapy for speech, hearing and language disorders” in the Evidence of Coverage.
- **Nutrition services:** Covered as described under “nutritional counseling” in the Evidence of Coverage.

Note: For Tufts Health Plan Commercial Members and Tufts Health Direct Members, orthodontic treatment and management, preventive and restorative dentistry, dental structures for orthodontic treatment or prosthetic management therapy are not covered for Members with cleft lip and or cleft palate past the Member's 18th birthday. For Tufts Health Together Members, orthodontic treatment and management, preventive and restorative dentistry, dental structures for orthodontic treatment or prosthetic management therapy are not covered for Members with cleft lip and or cleft palate past the Member's 22nd birthday.

REFERENCES

1. Commonwealth of Massachusetts General Law, Chapter 234 of the Acts of 2012. An Act Relative to the Treatment of Cleft Palate and Cleft Lip. <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter234>. Accessed October 12, 2020.
2. Commonwealth of Massachusetts MassHealth Provider Manual Series; Transmittal Letter ALL-205: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services https://www.mass.gov/doc/all-205-revisions-to-regulations-for-the-affordable-care-act/download?_ga=2.41018658.1447162086.1596638823-759518519.1596138383. Accessed October 21, 2020.

3. Commonwealth of Massachusetts Division of Medical Insurance 130 CMR 420.000: Dental Services. <https://www.mass.gov/doc/130-cmr-420-dental-services/download>. Accessed October 21, 2020.

APPROVAL HISTORY

Prior authorization, with Medical Necessity Guideline DMS# 1035155, for surgery for the treatment of Cleft Lip and Cleft Palate, was required for all Members from 1998 until 2002 and for Members only over the age of 19 from 2002 until 2012, when prior authorization was no longer required.

January 18, 2013: This coverage guideline created to provide information related to the Massachusetts General Law, Chapter 234 of the Acts of 2012 was reviewed by the Integrated Medical Policy Advisory Committee (IMPAC).

Subsequent endorsement date(s) and changes made:

- January 8, 2014: Reviewed by IMPAC without changes.
- December 10, 2014: Reviewed by IMPAC, renewed without changes. ICD-10 codes will be added prior to the next IMPAC approval.
- January 14, 2015: Reviewed by IMPAC. Added language to include coverage until Member's 22nd birthday for Tufts Health Plan - Network Health Medicaid Plan Members.
- March 18, 2015: Coding updated.
- August 12, 2015: Reviewed by IMPAC, renewed without changes.
- 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.
- March 17, 2016: Coding updated; ICD-9-CM codes removed
- August 26, 2016: Change to overview language to clarify different age limits for Tufts Health Commercial/Tufts Direct and Tufts Health Together plans.
- September 14, 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
- August 9, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- June 19, 2019: Administrative update.
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- December 6, 2019: References to Medical Necessity Guidelines: Habilitative Services for Physical Therapy, Occupational Therapy and Speech Therapy, Rehabilitative Services: Speech Therapy and Outpatient Physical Therapy, Occupational Therapy and Speech Therapy added/updated to clarify coverage of these services may require prior authorization.
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- October 30, 2020: References updated
- November 2, 2020: Fax number for Unify 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.

[Provider Services](#)