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

Effective: August 9, 2017

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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

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**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q35.1</td>
<td>Cleft hard palate</td>
</tr>
<tr>
<td>Q35.3</td>
<td>Cleft soft palate</td>
</tr>
<tr>
<td>Q35.5</td>
<td>Cleft hard palate with cleft soft palate</td>
</tr>
<tr>
<td>Q35.7</td>
<td>Cleft uvula</td>
</tr>
<tr>
<td>Q35.9</td>
<td>Cleft palate, unspecified</td>
</tr>
<tr>
<td>Q36.0</td>
<td>Cleft lip, bilateral</td>
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<tr>
<td>Q36.1</td>
<td>Cleft lip, median</td>
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<tr>
<td>Q36.9</td>
<td>Cleft lip, unilateral</td>
</tr>
<tr>
<td>Q37.0</td>
<td>Cleft hard palate with bilateral cleft lip</td>
</tr>
<tr>
<td>Q37.1</td>
<td>Cleft hard palate with unilateral cleft lip</td>
</tr>
<tr>
<td>Q37.2</td>
<td>Cleft soft palate with bilateral cleft lip</td>
</tr>
<tr>
<td>Q37.3</td>
<td>Cleft soft palate with unilateral cleft lip</td>
</tr>
<tr>
<td>Q37.4</td>
<td>Cleft hard and soft palate with bilateral cleft lip</td>
</tr>
<tr>
<td>Q37.5</td>
<td>Cleft hard and soft palate with unilateral cleft lip</td>
</tr>
<tr>
<td>ICD-10 Code</td>
<td>Description</td>
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</tr>
<tr>
<td>Q37.8</td>
<td>Unspecified cleft palate with bilateral cleft lip</td>
</tr>
<tr>
<td>Q37.9</td>
<td>Unspecified cleft palate with unilateral cleft lip</td>
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</tbody>
</table>

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 which may require prior authorization:

- Dental Procedures Requiring Hospitalization
- Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders
- Osteogenesis Distraction for Cranial Deformities
- Reconstructive and Cosmetic Surgery
- Rhinoplasty
- Scar Revision
- 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**

2. Commonwealth of Massachusetts MassHealth Provider Manual Series; Transmittal Letter ALL-205: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
3. 130 CMR: Division of Medical Assistance; 420.453: Oral and Maxillofacial Surgery Services

**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

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.