Medical Necessity Guidelines: Osteogenesis Distraction for Cranial Deformities

Effective: July 20, 2017

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<td>Applies to:</td>
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<tr>
<td>☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409</td>
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<tr>
<td>☐ Tufts Health Public Plans products</td>
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<tr>
<td>☐ Tufts Health Direct — Health Connector; Fax: 888.415.9055</td>
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<tr>
<td>☐ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055</td>
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<tr>
<td>☐ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607</td>
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<tr>
<td>☐ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
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<tr>
<td>☒ Tufts Health Freedom Plan products; Fax: 617.972.9409</td>
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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.

OVERVIEW
Osteogenesis distraction, or distraction osteogenesis (DO) was introduced as an early alternative to cranial and orthognathic surgery. The technique is now being used in the correction of severe craniofacial anomalies. DO creates a controlled fracture in a bony structure, then separates the bony segments in a controlled and gradual manner (Chin, 2006).

COVERAGE GUIDELINES
Tufts Health Plan may authorize coverage of distraction osteogenesis for the correction of a congenital or acquired cranial deformity when both of the following criteria are met:
- The Member has one of the following cranial deformities:
  - Micrognathia in infants and children accompanied by airway obstruction (e.g., Pierre Robin sequence, Treacher Collins, or Stickler syndromes)
  - Mandibular deficiency that requires lengthening of more than 10 mm
  - Lengthening a short mandibular ramus
  - Hemifacial microsomia in children with sufficient bone length to anchor an external or internal distraction device
  - Craniosynostosis
- The Member has one of the following functional impairments:
  - Persistent difficulty with mastication and swallowing and neurological or metabolic diseases have been excluded
  - Malnutrition, significant weight loss or failure to thrive secondary-to-skeletal facial deformity
  - Other severely handicapping impediments directly attributed to skeletal deformity, such as documented sleep apnea, neurological deficits.

LIMITATIONS
Tufts Health Plan will not cover osteogenesis distraction for either of the following because they are considered not medically necessary:
- Performed in preparation for dental implants or orthodontic care
- Performed for the sole purpose of improving appearance
- Performed for the treatment of snoring

CODES
The following CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>20690</td>
<td>Application of a uniplane (pins or wires in one plane), unilateral, external fixation system</td>
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<tr>
<td>20692</td>
<td>Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (e.g., Ilizarov, Monticelli type)</td>
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<td>Code</td>
<td>Description</td>
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<tr>
<td>20693</td>
<td>Adjustment or revision of external fixation system requiring anesthesia (e.g., new pin(s) or wire(s) and/or new ring(s) or bar(s))</td>
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</table>

**REFERENCES**

- Chin, M. Introduction to Distraction Osteogenesis. Retrieved on December 12, 2006 from distraction.net/pages/chapter1.html

**APPROVAL HISTORY**

February 1, 2007: Reviewed by the Medical Affairs Medical Policy Committee

Subsequent endorsement date(s) and changes made:

- April 18, 2008: CPT Codes added.
- December 2009: Reviewed by Medical Policy, no changes
- April 1, 2010: Reviewed at Medical Specialty Policy Advisory Committee (MSPAC); in bullet #2 replaced Airway obstruction with "documented sleep apnea"; "Treatment of snoring" added as limitation.
- April 2011: Reviewed by MSPAC, no changes
- February 8, 2012: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), no changes
- March 13, 2013: Reviewed by IMPAC, administrative process changed from MD to RN
- December 10, 2014: Reviewed by IMPAC, renewed without changes
- September 9, 2015: Reviewed by IMPAC. Removed CPT 20694 from prior authorization.
- 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.
- July 20, 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
- July 20, 2017: Reviewed 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.