

Document ID#: 2107135
Subject: Osteogenesis Distraction for Cranial Deformities
Effective Date: December 1, 2009

| | | | |
|---|---|--|----|
| Clinical Documentation and Prior Authorization Required | √ | Type of Review - Case Management | |
| Not Covered | | Type of Review – Precertification Department | √ |
| | | Administrative Process (Internal Use Only) | MD |

Note: Background, product, and disclaimer information is located at the end of this document.

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
 - Craniosyntosis
- 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 airway obstruction, 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

Codes

The following CPT codes require prior authorization:

| Code | Description |
|-------|--|
| 20690 | Application of a uniplane (pins or wires in one plane), unilateral, external fixation system |
| 20692 | Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (e.g., Ilizarov, Monticelli type) |
| 29693 | 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)) |
| 20694 | Removal, under anesthesia, of external fixation system |

References

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

Approval History

Reviewed by the Medical Affairs Medical Policy Committee on February 1, 2007.

Subsequent Endorsement Date(s) and Changes Made:

- April 18, 2008: CPT Codes added.
- December 2009: Reviewed by Medical Policy, no changes

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes 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, but 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 Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred 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 will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

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.