MEDICAL COVERAGE POLICY

SERVICE: **Endoscopic Surgery for Craniosynostosis**

Policy Number:	**294**
Effective Date:	**10/01/2024**
Last Review:	**09/09/2024**
Next Review:	**09/09/2025**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

SERVICE: Endoscopic Surgery for Craniosynostosis

PRIOR AUTHORIZATION: Required.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). Medicare NCD or LCD specific InterQual criteria may be used when available. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid Provider Procedures Manual | TMHP (TMPPM). If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

BSWHP may consider endoscopic surgery for craniosynostosis medically necessary when **BOTH** of the following criteria are met:

1. Member is age 6 months or less
2. Member has a diagnosis of **one or more** of the following:
   - Primary Craniosynotosis
   - Secondary Craniosynotosis
   - Simple Craniosynotosis
   - Compound Craniosynotosis

BACKGROUND:

Endoscopic surgery, such as endoscopy-assisted strip craniectomy or suturectomy, is less invasive than open cranial vault reconstruction and is best performed when the infant is younger than 6 months old. The surgeon uses an endoscope to remove the fused suture(s), which allows the growing brain to expand. A pediatric neurosurgeon or plastic surgeon makes two incisions in the scalp over either end of the fused suture, and a dissecting space is created beneath the scalp in a bloodless fashion using a rigid endoscope and an electrocautery device. The surgeon incises the skull at each end of the suture, and

after separating the dura (tough outer membrane covering the brain) from the overlying skull, makes two more incisions to form a rectangular strip. This strip of bone containing the fused suture is removed through the scalp incisions in one or two pieces. The operation normally lasts between 1 and 2 hours and most patients are discharged in 1 to 2 days.

After surgery, the infant wears a customized helmet that helps to mold the skull into a proper shape as the brain grows. Within 1 week of surgery, the infant is fitted with a customized helmet that applies pressure on abnormal bulges in the skull but allows for expansion in the correct direction. The helmet helps to guide the expanding skull to a normal shape over 11 to 12 months. Most patients typically need one or two helmets during the treatment period. Follow-up appointments occur every 2 to 3 months.

CODES:

Important note:
Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes	64999 - Unlisted procedure, nervous system
CPT Codes Not Covered	
ICD-10 Codes	
ICD-10 Codes Not Covered	

POLICY HISTORY:

Status	Date	Action
New	12/23/2021	New policy
Reviewed	12/29/2022	No changes
Reviewed	03/11/2024	Formatting changes, added hyperlink to TMPPM, beginning and ending note sections updated to align with CMS requirements and business entity changes.
Reviewed	09/09/2024	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement

Committee (QIC) to determine if a modification of the policy is in order.

***Note**:*
Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs.