

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Allergy Testing via Skin-Prick Testing

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making process regarding requests for allergy testing via the skin-prick method.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Definition

Skin-prick testing involves placing a small amount of a suspected allergy-causing substance (allergen) on the skin and then scratching/pricking the skin in order to introduce the substance under the skin. Multiple allergens may be introduced at the same time, thereby testing for several suspected allergies simultaneously. The patient is then observed for reaction to the allergen, manifested as swelling and redness at the site.

Skin-prick testing should be performed under the supervision of an allergy specialist.

Background

Environmental allergies in children are a common occurrence, especially among young children. Typical signs and symptoms include skin redness (erythema) and hives (urticaria). In addition to causing “seasonal allergy” symptoms such as rhinorrhea, nasal congestion, sneezing, coughing, and wheezing, environmental allergies can act as precipitating factors in several other atopic diseases such as asthma and eczema. Although severe reactions such as respiratory distress and anaphylaxis are rare, they are of significant concern in the pediatric population.

Skin testing represents the primary diagnostic tool in allergy that is used to confirm that a specific allergen, suggested by medical history, has induced an IgE antibody response. Percutaneous and intradermal skin tests to determine IgE-mediated immediate hypersensitivity are the most clinically applicable techniques in the assessment of allergic patients because of their simplicity, biological relevance in the patient’s own skin, rapidity of performance, low cost and high sensitivity. A positive IgE-mediated skin test manifests as a wheal and flare reaction. However, skin tests as with other physiologic measures require a degree of expertise by the observer to both interpret the results and correlate with the history and physical findings.

Initiated: 6/08

Revised:

Reviewed: 1/12, 3/6/13, 8/15/13, 2/20/14, 1/23/15, 7/1/16

Allergy Skin-Testing Guideline

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Allergy Testing via Skin-Prick Testing

Unit: Medical Services

Criteria to Substantiate Medical Necessity for Allergy Testing:

One or more of the following:

- Eczema
 - Requested by dermatologist
 - Prolonged use of topical steroids > 4 continuous weeks, without resolution
 - Steroids must be class V steroids or stronger
- Food Allergy
 - Requested by gastroenterologist, or
 - Etiology related to exposure to peanut or nut, or
 - Clearly delineates a true food sensitivity
- Seasonal allergy
 - Greater than six weeks of symptoms and
 - Failed trial of therapy with appropriate medications
 - Compliance demonstrated by prescription records
 - Must have documented appropriate follow-up with the medical provider
- Anaphylaxis or other life threatening allergic-type response
 - Etiology related to environmental allergen exposure
 - Etiology related to exposure to peanut or nut
- Recurrent angioedema or chronic or recurrent hives

References:

Sicherer, S., & Wood, R. A. (2011). Allergy testing in childhood: Using allergen-specific ige tests. *Official Journal of the American Academy of Pediatrics*, 129(1), 193-197.

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Medical Director

_____7/1/2016_____

Date

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Reviewed: 1/12, 3/6/13, 8/15/13, 2/20/14, 1/23/15, 7/1/16
Allergy Skin-Testing Guideline

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Circumcision

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making process regarding requests for circumcision.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Routine Circumcision in the Newborn

Routine newborn circumcision is not a covered service by AHCCCS or CMDP, as of October 2002.

Non-routine circumcision

Circumcisions that are considered medically necessary by the healthcare provider require a prior authorization by CMDP Medical Services. The request for authorization must be accompanied by documentation to substantiate medical necessity.

Background

Phimosis is a constriction of the prepuce resulting in an inability to retract the foreskin back over the glans. Developmental (physiological) nonretractile foreskin is very common in the toddler and young child. True phimosis (adhesion of the foreskin to the glans) is much less common. In 10% of uncircumcised 3-year-old boys, the foreskin cannot be fully retracted, but the foreskin will become fully retractable for nearly all the boys by the onset of puberty.

Balanitis (inflammation/infection of foreskin) is not common and, if it occurs, it is not an absolute reason to perform a circumcision. Pediatric urologists follow many children and young men longitudinally who do not desire circumcision, yet have repeated bouts of balanitis. This can be successfully managed medically (without surgical intervention).

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Circumcision Guideline 2016

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Comprehensive Medical and Dental Program Authorization Guideline

Subject: Circumcision

Unit: Medical Services

Criteria to Substantiate Medical Necessity for Circumcision:

- True phimosis (vs. developmental/physiological non-retractile foreskin) in a boy older than 6 years of age.
- True phimosis, which has failed an adequate trial of daily topical therapy (steroid therapy) for 4-6 weeks duration. [Betamethasone (a steroid cream) can be applied to gradually and gently break adhesions, if phimosis is a real concern.]
- Phimosis that has resulted in impaired urinary stream.
- Paraphimosis which causes the foreskin, once pulled back, to not return to its original location.
- Associated with other penile surgery

Other considerations may include:

- Balanitis or Balanoposthitis resulting in the need for repeated emergency department visits.
- Recurrent UTI's

References:

American Academy of Pediatrics (AAP) 1971, 1975, 1983, 1989 and March 1999, and 2011

Cost-effective Treatment of Phimosis; RS Van Howe. *Pediatrics* 1998;102;43-46

Postneonatal circumcision: population profile; GL Larsen, SD Williams. *Pediatrics* 1990;85(5);808-812

Circumcision in children beyond the neonatal period; TE Wiswell, et al. *Pediatrics* 1993;92(6):791-793

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Medical Director

____7/1/16_____
Date

Initiated: 8/2003
Reviewed: 4/2006; 1/2007; 11/2007; 06/2008; 1/2012; 4/10/13, 8/15/13, 3/13/14, 1/23/15, 7/1/16
Circumcision Guideline 2016

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Considerations for wart or other skin lesion removal

Unit: Medical Services

Purpose

This guideline is used in the prior authorization decision-making process regarding requests for removal of warts or other skin lesions such as, but not limited to, molluscum, uncomplicated nevi, keloids and skin tags.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Routine skin lesion debridement

Warts are a common pediatric problem, affecting 10% of the population at some time. Although it is impossible to predict the natural history of individual warts, studies conducted in children indicate that 66% of lesions resolve spontaneously within 2 years.

A number of therapies exist, but the response to any given treatment method is variable. Among the most common treatments are the application of a keratolytic agent (e.g., those containing salicylic acid) and cryotherapy (liquid nitrogen/freezing), each of which has an ultimate cure rate of only 75%. Adverse outcomes are reported to be more frequent and more severe in cryotherapy.

Complications of treatment include:

- Fear and discomfort that the child experiences,
- Complications such as blisters, infections and alterations of the pigmentation of the skin,
- Permanent scarring, and
- The need for frequent clinic visits for successful treatment.

The best available evidence supports the use of topical treatments that contain salicylic acid, which can be found in over-the-counter (OTC) products. Such preparations have been shown to have a modest, but significant, treatment benefit over placebo (no treatment). Studies have suggested that the application of adhesive tape/duct tape may also be as effective as or more effective than conventional treatment. In one report, the application of duct tape produced a cure rate of 85%, which is more effective than cryotherapy and has no complications.

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Considerations for wart or other skin lesion removal

Unit: Medical Services

Wart Removal

Medically necessary wart removal is a covered service for CMDP eligible members. The procedure requires prior authorization (PA) by CMDP when performed by a dermatologist. The member's healthcare provider must submit appropriate documentation to substantiate medical necessity. Medically necessary wart removal by primary care providers (PCP) does not require PA.

All cases of warts should be individually assessed and the choice of therapy selected based upon the age of the patient existence of pain or discomfort and the number, size, location, and distribution of the warts.

Considerations for Treatment:

- The child/youth is in some way symptomatic, i.e., has significant pain, bleeding and/or irritation from the warts or skin condition.
- The warts or skin condition is growing, or is in an area of the body where they are subject to repeated trauma.
- The warts or skin condition is spreading in a larger distribution.
- The child is causing irritation to the warts or skin condition and therefore possibly increasing the distribution of the warts or skin condition.
- The warts or skin condition are on the face especially near the eyes and causing impaired function (vision)

Warts or skin condition can be a self-limited viral infection that will resolve spontaneously. Treatment, if at all, should be conservative to avoid unnecessary trauma to the child/youth and unnecessary scarring as a result of the treatment.

References

Clinical Pediatric Dermatology – A Textbook of Skin Disorders of Childhood and Adolescence. Hurwitz. Second edition.

**Comprehensive Medical and Dental Program
Authorization Guidelines**

Subject: Considerations for wart or other skin lesion removal

Unit: Medical Services

Sanders Bellet, J. (2013). Developmental anomalies of the skin. In *Seminars in Perinatology* (2013 ed., Vol. 37, pp. 20-25). Durhan, NC: Elsevier.

Schneider, M., Meites, E., & Daane, S. (n.d.). Keloids: Which treatment is best for your patient:. *The Journal of Family Practice*, 62(5), 227-233.

Sethuraman, G., Bhari, N., & Pandhi, B. (n.d.). Common Skin Problems in Children. *Pediatrics in General Practice*, 81(4), 381-390.

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Medical Director

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Date

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Consults by Developmental/Behavioral Pediatricians

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making process regarding requests for consultation by developmental pediatrician.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

Developmental-Behavioral Pediatricians (DBPs) have special training which gives them expertise in the evaluation and treatment of children, adolescents, and their families with a wide range of developmental and behavioral difficulties. These include: learning disorders, attention and behavioral disorders, tic disorders, regulatory disorders, discipline difficulties, developmental disabilities/disorders, autism spectrum disorders, and disorders related to chronic illness and disabling conditions.

There is much crossover in the expertise of the Developmental/Behavioral Pediatrician and thus their services are now available through the public medical health plan (CMDP) and the behavioral health system (RBHA), depending on the nature of the child's presenting medical problem.

Overview

Depending on the nature of the clinical presentation, the DBPs may be consulted to provide service through either public health system (medical or behavioral). In order for a DBP to participate as a CMDP provider, it will be imperative that they are registered as providers with both CMDP and the assigned RBHA providing the child's care. In this way, they will be able to appropriately coordinate care between the medical and behavioral health systems.

In general, health plans are responsible to provide medically necessary developmental services when the concerns expressed relate to developmental delays with physical health implications, including the need for outpatient therapy services. The RBHAs are responsible when the services focus around behavioral issues, including the possibility of autism. The school districts are responsible when the concerns affect learning ability and school performance, as well as the performance of appropriate testing and the development of an Individualized Education Plan.

Initiated: 8/12
Revised: 6/5/13
Reviewed: 3/20/14, 1/23/15, 7/1/16

Developmental/Behavioral Pediatric Consults

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Comprehensive Medical and Dental Program Authorization Guideline

Subject: Consults by Developmental/Behavioral Pediatricians

Unit: Medical Services

A request for consultation with a Developmental Behavioral Pediatrician (DBP) by CMDP must be initiated by the child /adolescent's Primary Care Provider who has completed a recent EPSDT, including the appropriate behavioral and developmental screening. The services, including **developmental testing** to be provided by the DBP must be expected to contribute to a diagnostic or functional determination that will contribute to a change in the treatment plan, which is anticipated to improve the member's condition.

The role of the Developmental/Behavioral Pediatrician through CMDP

Specific referral questions for the consulting DBP that will influence the medical management of the child or adolescent and relate to developmental disabilities and/or complex medical issues. Examples include:

- **Developmental disabilities** including cerebral palsy, spina bifida, mental retardation, and visual and hearing impairments.
- **Regulatory disorders** including sleep disorders, feeding problems, complicated toilet-training issues, enuresis, and encopresis. Enuresis could be appropriately treated by the PCP, DBP, or RBHA depending on the nature of the problem. Some issues, such as encopresis will be most successfully treated with joint input from the RBHA & medical providers.
- **Tics and Tourette syndrome**, unless the disorder is related to a behavioral health medication. That would be addressed by the RBHA.

The role of the Developmental/Behavioral Pediatrician through the RBHA

Again, specific referral questions for the consulting DBP that could lead to necessary recommendations for behavioral health treatment. Examples include:

- **Attention and behavioral disorders** including attention-deficit/hyperactivity disorder, depression, and anxiety disorders. These disorders must be addressed by the PCP or RBHA. The DBPs can only be consulted by the RBHA in this scenario. CMDP will not pay a DBP to consult on behavioral health issues.
- **Oppositional-defiant behavior**, conduct problems, and discipline difficulties
- **Autism Spectrum Disorders**, other habit disorders

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Developmental/Behavioral Pediatric Consults

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Comprehensive Medical and Dental Program Authorization Guideline

Subject: Consults by Developmental/Behavioral Pediatricians

Unit: Medical Services

The role of the educational system

The educational system (AzEIP - for children under 3 years or the School District - for children 3 years and older) is responsible for:

- The evaluation of delayed development in speech, language, motor skills, and thinking ability.
- The evaluation of learning disorders including dyslexia, writing difficulties, math disorders, and other school-related learning problems.
- Testing to determine if a child has intellectual disability (mental retardation).

References:

FREQUENTLY ASKED QUESTIONS DEVELOPMENTAL/BEHAVIORAL PEDIATRICIANS
ROLE AS PART OF ARIZONA'S PUBLICLY FUNDED BEHAVIORAL HEALTH PROVIDER
NETWORK

<http://www.azdhs.gov/bhs/children/pdf/DevelopmentalBehavioralFAQs.pdf>

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Medical Director

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Date

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Developmental/Behavioral Pediatric Consults
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Comprehensive Medical and Dental Program Authorization Guideline

Subject: Cranial Banding (Cranial Orthosis)

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making process regarding requests for cranial banding.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

Plagiocephaly is a type of cephalic disorder characterized by an asymmetrical distortion (flattening) of one side of the skull. It is a common finding at birth and may be the result of a restrictive intrauterine environment. If there is premature union of skull bones, this is more properly called craniosynostosis.

Positional plagiocephaly, also known as deformational plagiocephaly, is a condition most commonly found in infants and is characterized by a flat spot on the back or one side of the head caused by remaining in one position for too long. It can be caused by a condition called torticollis in which neck muscles on one side of the head develop differently, causing the head to tilt to one side, but more commonly it happens in infants of ordinary development who sleep in one position for long periods of time. Prognosis for this condition is excellent and can be reversed in most cases before one year of age. Treatment can be as simple as repositioning the child's head while sleeping and increasing the time spent on the belly. In some cases, special fitted helmets can be used. Once a child starts moving on his/her own, the condition may improve by itself. The flattening of the head, while alarming, does not typically harm the brain or hinder its development.

Brachycephaly refers to shortened antero-posterior diameter of the skull.

Cranial Bands are usually made of an outer hard shell with a foam lining. Gentle, persistent pressures are applied to capture the natural growth of an infant's head, while inhibiting growth in the prominent areas and allowing for growth in the flat regions. As the head grows, adjustments are made frequently. The helmet essentially provides a tight, round space for the head to grow into. Cranial band use is ideally done between 4 months and 12 months of age and is designed to be used for approximately 2 – 4 months.

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Cranial Banding (Cranial Orthosis)

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Cranial Banding (Cranial Orthosis)

Unit: Medical Services

Appropriate Patient Selection

Cranial bands are considered medically necessary for moderate to severe positional head deformities associated with prematurity, restrictive intra-uterine positioning, cervical abnormalities, torticollis and sleep positioning in children under certain circumstances:

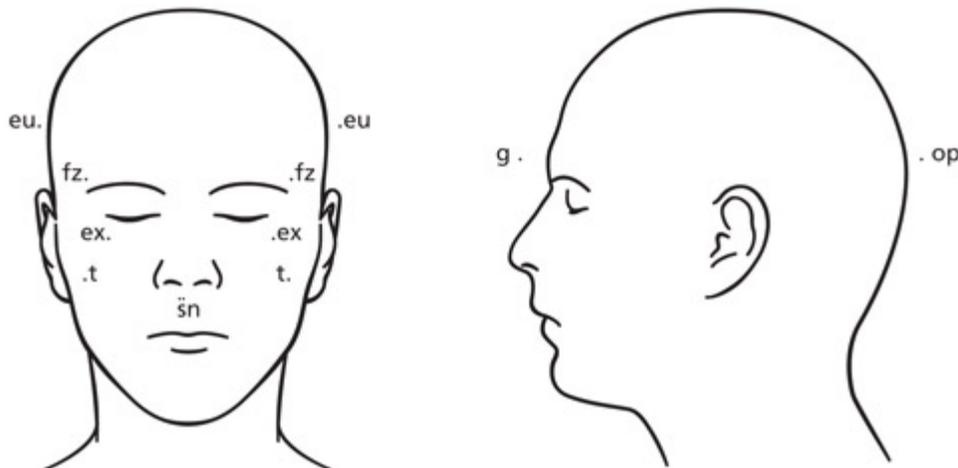
A two-month trial of conservative therapy has failed

- Repositioning of child's head away from the preferred side
- Treatment of torticollis with physical therapy
- Documentation of pediatric visits and assessment by an experienced clinician

If a two-month trial has failed, cranial orthotics may be instituted if one of the following criteria is met:

For Plagiocephaly:

Anthropometric data verifies that a moderate to severe plagiocephaly exists. (Data may be obtained by orthotist).



Asymmetry of greater than 6mm between anthropometric measurements of cranial base (sn – t), cranial vault (fz – eu), or orbitotragial (ex – t) depth warrant a trial of cranial banding.

For Brachycephaly:

A brachycephalic skull is relatively broad and short (typically with the breadth at least 80% of the length). The evaluation for this consists of obtaining a cephalic index.

Cephalic Index = $\frac{\text{Head width (eu – eu)} \times 100}{\text{Head length (g – op)}}$

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Cranial Banding (Cranial Orthosis)

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Cranial Banding (Cranial Orthosis)

Unit: Medical Services

A cephalic index greater than 2 standard deviations above or below the mean warrants a trial of cranial banding.

	Age	-2SD	-1SD	Mean	+1SD	+2SD
Male	16 days to 6 months	63.7	68.7	73.7	78.7	83.7
	6 - 12 months	64.8	71.4	78.0	84.6	91.2
Female	16 days to 6 months	63.9	68.6	73.3	78.0	82.7
	6-12 months	69.5	74.0	78.5	83.0	87.5

Other factors which may warrant cranial orthotic include:

Premature infants with dolichocephalic head shape (a dolichocephalic skull is a relatively long skull, specifically having a cephalic index of < 75% for females and < 65% for males) secondary to sustained position

Infants with misshapen head secondary to constant head position required for hyperalimentation

Infants with residual plagiocephaly after surgical correction

Infants with massive hydrocephalus who continue to have increasing head size despite neurosurgical management with one or more Ventriculo-Peritoneal (VP) shunt.

References:

www.aetna.com/cpb/medical/data/300_399/0379.html

Diagnosis and Management of Posterior Plagiocephaly. Ian F. Pollack, H. Wolfgang Losken and Patricia Fasick. *Pediatrics* 1997;99;180-185.

Prevention and Management of Positional Skull Deformities in Infants. John Persing, Hector James, Jack Swanson, John Kattwinkel, Committee on Practice and Ambulatory Medicine, Section on Plastic Surgery and Section on Neurological Surgery. *Pediatrics* 2003;112;199-202

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Medical Director

_____ 7/1/16 _____
Date

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Reviewed: 1/12, 3/13/13, 8/15/13, 3/20/14, 3/5/15, 7/1/16
Cranial Banding (Cranial Orthosis)

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Criteria for Use of Recombinant Growth Hormone in Children

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making process regarding requests for Recombinant Growth Hormone (rGH).

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

Research indicates that growth hormone (GH) alone, or in combination with anabolic steroids, improves the growth rate in children with growth hormone deficiency.

Use of rGH in Children

The CMDP Medical Management (MM) Committee recommends that rGH be used only for growth hormone resistant or deficient states and that it should only be prescribed and monitored by a Pediatric Endocrinologist. Because of cost and potential side effects, prudent use is recommended.

GH replacement for deficiency states:

- *Classical growth hormone (GH) deficiency*
Infants may present with hypoglycemia-related seizures, visual defects, or micropenis.
- *Acquired forms of GH deficiency*
Head trauma – transection of pituitary stalk/injury to pituitary gland, intracranial lesions, irradiation therapy – greater than 2,400 rads of cranial radiation, therapy that is associated with abnormal spontaneous generation of growth hormone.

Patients are usually treated from ~4 years of age through puberty. There is an expectation that children should have a growth rate of ≥ 5 cm (2 inches) per year.

GH-resistant states with abnormal growth velocity of <5 cm/year, such as Chronic Renal Failure while awaiting transplantation: The goal is to maintain age-appropriate growth so that with the re-establishment of normal GH responsiveness after transplantation, children might attain a final adult height that is more consistent with their genetic potential.

The response to rGH therapy in growth-resistant states should yield a growth rate of ≥ 2.5 cm/6 months or ≥ 5 cm/year. The CMDP MM Committee recommends discontinuing rGH if the rate of growth is <5 cm/year, generally around the chronological age of 12 or 13.

Initiated: 08/2003

Reviewed: 01/2005, 11/2005, 3/2007, 11/2007, 06/2008, 1/2010, 5/1/13, 4/24/14, 1/23/15, 7/1/16

Criteria for Use of Recombinant Growth Hormone in Children Guideline 2016

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Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Criteria for Use of Recombinant Growth Hormone in Children

Unit: Medical Services

Criteria to Substantiate Medical Necessity for rGH

The child must have a **diagnosis consistent with a GH deficiency state** and the following criteria must all be met:

- Use must be for an FDA-approved condition,
- The child must have proportionate short stature with height < 5th percentile on a standardized growth chart,
- The child must have an abnormal growth velocity, as demonstrated on growth chart (< 5 cm/year),
- The child must have a delayed bone age > 2 SD from the norm, as compared with chronological age,
- The child must have failed a growth hormone stimulation test, with a peak <10 micrograms/ml, **and**
- The child must have an absence of chronic disease, psychosocial dwarfism or malnutrition.

OR

The child must have a **diagnosis consistent with a GH resistant state** and demonstrate an abnormal growth velocity.

- Use must be for an FDA-approved condition,
- The child must have proportionate short stature with height < 5th percentile on a standardized growth chart,
- The child must have an abnormal growth velocity, as demonstrated on growth chart (< 5 cm/year),

Once initial PA is received, continued authorization is required on a semi-annual basis.

- Must document compliance, annualized growth velocity, benefits of continued treatment.

Considerations for Discontinuing rGH Therapy

- Decrease in growth velocity while on rGH therapy, i.e. <5 cm/year,
- Bone age of:
 - >14 years in females
 - >16 years in males
- Poor compliance, **or**
- Attained height of the child/youth that is within genetic potential, as defined by midparental height:
 - For males = $([\text{mother's height} + 13\text{cm}] + \text{father's height})/2$
 - For females = $([\text{father's height} - 13\text{ cm}] + \text{mothers height})/2$

Initiated: 08/2003

Reviewed: 01/2005, 11/2005, 3/2007, 11/2007, 06/2008, 1/2010, 5/1/13, 4/24/14, 1/23/15, 7/1/16

Criteria for Use of Recombinant Growth Hormone in Children Guideline 2016

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**Comprehensive Medical and Dental Program
Authorization Guidelines**

Subject: Criteria for Use of Recombinant Growth Hormone in Children

Unit: Medical Services

*(Calculations must be in cm)

References:

- Review and update lecture to AHCCCS Medical Directors on June 27, 2003 by Dr. Khalid Hasan, Director Pediatric Endocrinology, Phoenix Children's Hospital
PCH Grand Rounds, Dr. Mahmoud Kabbani. Short Stature on November 15, 2005
Kemp SF, Kuntze J, Attie KM, et al. Efficacy and safety results of long-term growth hormone treatment of idiopathic short stature. *J Clin Endocrinol Metab.* 2005; 90:5247-5253.
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Hintz RL, Attie KM, Baptista J, Roche A. Effect of growth hormone treatment on adult height of children with idiopathic short stature. *N Engl J Med.* 1999;340:502-507.
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Wudy SA, Hagemann S, Dempfle A, Ringler G, Blum WF, Berthold ID, Alzen G, Gortner L, Hebebrand J. Children With Idiopathic Short Stature Are Poor Eaters and Have Decreased Body Mass Index. *Pediatrics* 2005;116:e52-e57
MMC Grand Rounds, Dr. Chirag Kapadia. Interpretation of Growth Curves in Children on January 12, 2010.

Signature on file

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7/1/16

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Criteria for Use of Recombinant Growth Hormone in Children Guideline 2016

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Comprehensive Medical and Dental Program Clinical Guidelines

Subject: Frenectomy Indications for Ankyloglossia

Unit: Medical Services

Policy:

This policy's intended use is as a clinical guideline for determining medical necessity in the review of prior authorizations requesting frenectomy, also known as frenulectomy, for ankyloglossia.

The following guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Indications for the use of Frenectomy (tongue clipping) for Ankyloglossia (tongue-tie)

There is a great deal of controversy in the medical literature regarding the standard of care for an infant with ankyloglossia (or tongue-tie). There are generally two periods of time in which this issue may pose a problem. The first is in early infancy in which the presentation is not only the inability to latch onto the breast effectively, but also failure to gain weight appropriately.

Infants with mild to moderate tongue-tie are likely to breastfeed successfully and usually require no treatment. Many times the tongue-tie will tear spontaneously and the situation will resolve itself. If the infant with any degree of tongue-tie has difficulty with breastfeeding, they need immediate lactation support. If the problem is not resolved with intensive lactation support, the medical literature supports tongue clipping. Frenotomy, frenectomy, and frenuloplasty are the main surgical treatment options to release/remove an ankyloglossia (tongue-tie). Complications from the procedure are minimal.

Later in life, around the ages of 3-4, children with untreated tongue-tie may develop articulation difficulties and "substitution errors" in which they incorrectly substitute one sound (that they can make) for another that they are unable to make. The front of the tongue is bound down and they are unable to roll the tongue forward to make certain sounds (like the "T" sounds).

**Comprehensive Medical and Dental Program
Clinical Guidelines**

Subject: Frenectomy Indications for Ankyloglossia

Unit: Medical Services

CMDP will consider authorization of this procedure for the following criteria:

- Young infant in the first few weeks of life with feeding difficulties and failure to gain weight appropriately (follow curve on standardized growth chart).
- Child is age 2-4 years and has significant articulation errors.

References:

Obladen M. Much ado about nothing: two millenia of controversy on tongue-tie. *Neonatology* Jan 2010; 97(2): 83-9

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Signature on file
Medical Director

7/1/16
Date

Initiated: 01/2011
Revised:
Reviewed: 7/6/11; 5/8/13; 8/15/13; 4/10/14; 2/19/15; 7/1/16
Frenectomy Indications for Ankyloglossia

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Genetic Testing

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making process regarding requests for genetic consultation and/ or genetic testing, including:

- Karyotype (chromosome banding)
- High Resolution Chromosome Analysis
- Fluorescent in-situ Hybridization (FISH)
- Chromosome Microarray Testing (CMA)

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note the information contained in this guideline may be updated.

Chromosome studies

Chromosome studies are used to potentially determine a cause for developmental delay/mental retardation, birth defects, dysmorphic features, and/or autism, as well as multiple other medical conditions. Chromosome analysis is also performed in the prenatal setting to determine whether a fetus is affected with aneuploidy or other chromosome rearrangements. Finally, chromosome abnormalities are often detected in cancer samples. A number of different methods have been developed for chromosome analysis.

- Karyotype describes the number of chromosomes and their appearance under a light microscope using special stains that generate light and dark bands. Attention is paid to the length, the position of the centromeres, banding pattern, any differences between the sex chromosomes, and any other physical characteristics, allowing identification of each chromosome under a microscope.
- High Resolution Chromosome Analysis is the analysis of the number and structure of the chromosomes when cell division has been arrested and the chromosomes stained at an early stage (pro-metaphase) of mitosis. The chromosomes of a high-resolution study appear longer and reveal 700-1200 bands, allowing more detailed analysis of the chromosome structure, as opposed to the typical 300-600 bands observed with routine metaphase banding in karyotyping.
- Fluorescence in-situ Hybridization involves fluorescent labeling of probes that bind to specific DNA sequences; it is used for identifying aneuploidy, genomic deletions or duplications, characterizing chromosomal translocations and determining the origin of ring chromosomes.
- Chromosome Microarray Testing is a molecular technique that involves adhering an individual DNA sample to a glass slide or microarray chip containing molecular probes that represent unique regions of the genome. This method is particularly sensitive for detection

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Genetic Testing

Unit: Medical Services

of genomic gains or losses across the genome but does not detect balanced translocations or distinguish the location of duplicated genetic material.

Currently in the United States, no regulations are in place for evaluating the accuracy and reliability of genetic testing. Most genetic tests developed by laboratories are categorized as services, which the Food and Drug Administration (FDA) does not regulate. Only a few states have established regulatory guidelines. The AAP and ACMG strongly discourage the use of direct-to consumer and home kit genetic testing of children because of the lack of oversight on test content, accuracy, and interpretation.

Clinical Considerations:

When ordering a genetic test, practitioners should be cognizant of what information each different type of genetic test can yield and order genetic testing with the following questions in mind:

- What medical questions do you expect to have answered by genetic testing?
- What specific condition(s) are suspected?
- How will the results of the genetic testing affect the course of medical treatment?
- What changes in treatment, referral, or prognosis should we expect to see as a result of the genetic testing?

Conventional karyotyping may be more appropriate when a common aneuploidy is suspected. It would be appropriate to order a FISH with a single probe to confirm a suspected diagnosis of a well-described syndrome, such as Williams's syndrome.

Additionally, a microarray should not be ordered when a rapid turnaround time is needed, such as in the case of a STAT newborn analysis, especially if a chromosomal trisomy is suspected.

Criteria to Substantiate Medical Necessity for Genetic Testing:

Genetic testing is only approved when the results of such testing are necessary to differentiate between treatment options. Genetic testing will not be approved to determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatments of the member. Genetic testing is not approved to determine the likelihood of associated medical conditions occurring in the future when conventional testing is available to test for the medical conditions (e.g., renal disease, hepatic disease) that may be associated with an underlying genetic condition.

**Comprehensive Medical and Dental Program
Authorization Guideline**

Subject: Genetic Testing

Unit: Medical Services

Genetic testing is not approved as a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly. Genetic testing is not approved for purposes of determining current or future family planning.

Predictive genetic testing for adult onset conditions generally should be deferred unless an intervention initiated in childhood may reduce morbidity or mortality. An exception might be made for families for whom diagnostic uncertainty poses a significant psychosocial burden, particularly when an adolescent and his or her parents concur in their interest in predictive testing.

Genetic testing is not approved to determine whether a member carries a hereditary predisposition to cancer or other diseases. Genetic testing is also not approved for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.

When genetic testing is appropriate and medically necessary, CMDP will only approve the most specific test to address the issue involved. In addition, providers must specify the number of units for the requested test.

Signature on file
Medical Director

7/1/16
Date

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Medical Marijuana Guidelines

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making processes regarding requests for medical marijuana.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

In 2010, the registered voters of Arizona passed a proposition permitting the use of medical marijuana for the relief of a debilitating medical condition if recommended by certain stipulated health care professionals (e.g., medical doctor, doctor of osteopathy, naturopath). The legislation applies to all age groups including those under the age of 18. Thus, it is possible that medical marijuana could be prescribed for a CMDP member.

The AAP has concluded the following: “The American Academy of Pediatrics supports rigorous scientific research regarding the use of cannabinoids for the relief of symptoms **not currently ameliorated by existing legal drug formulations** [emphasis added].”

Medical Marijuana is not an AHCCCS Covered Service

Under 42 CFR § 440.120 marijuana does not qualify as a federally reimbursable medication. AHCCCS does not currently cover and has never covered medical marijuana as a medical or pharmacy benefit. Marijuana is not a prescribed drug or medication. It is merely “recommended” and not dispensed through a pharmacy.

Because there is no peer reviewed literature to support its use in the pediatric population over other well studied, safer, and more efficacious drugs, it will not be covered by CMDP. Children or youth who come into care with medical marijuana cards will be immediately evaluated by a selected primary care provider and behavioral health provider with expertise in chronic pain disorders, substance abuse, and/or mental health expertise. As there is no physiologic withdrawal from marijuana, other appropriate therapeutic recommendations will be made.

**Comprehensive Medical and Dental Program
Authorization Guideline**

Subject: Medical Marijuana Guidelines

Unit: Medical Services

References

Legalization of Marijuana: Potential Impact on Youth, Committee on Substance Abuse and Committee on Adolescence, *Pediatrics* 2004; 113; 1825-1826 DOI: 10.1542/peds.113.6.1825

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AHCCCS Medical Policy Manual Section 320-M

Signature on file
Medical Director

July 1, 2016
Date

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Myringotomy and Tympanostomy Tube Insertion

Unit: Medical Services

Purpose:

This guideline is used in the prior authorization and decision-making process regarding requests for myringotomy and placement of tympanostomy tubes.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Definition:

Myringotomy – incision of the tympanic membrane to allow ventilation of the middle ear, drainage of middle ear fluid, or to obtain cultures from an infected middle ear.

Tympanostomy Tubes – tubes which are placed within an incision made during myringotomy into the eardrum in order to keep the middle ear aerated for a prolonged period of time, and to prevent the accumulation of mucus in the middle ear.

Otitis media with effusion (OME) - presence of a middle ear effusion (MEE) without signs or symptoms of infection. This was previously called serous or secretory otitis media (SOM). OME that persists beyond 3 months often is called chronic otitis media or chronic otitis media with effusion.

Acute otitis media (AOM) – an infection of the middle ear with acute onset, presence of MEE and signs of middle ear inflammation. Treatment-failure of AOM is a lack of improvement in signs and symptoms within 48 to 72 hours after initiation of antibiotic therapy.

Recurrent AOM – three (3) or more AOM episodes occurring in the previous 6 months or four or more AOM episodes in the preceding 12 months.

Chronic suppurative otitis media (CSOM) – purulent otorrhea which is associated with a chronic perforation of the eardrum and active bacterial infection within the middle ear space which lasts for 6 weeks or more, despite appropriate treatment for AOM.^{1,2}

Initiated: 10/2008

Reviewed: 11/2008; 03/2009; 9/2009; 9/30/10; 3/27/13; 5/22/14; 1/23/15; 7/11/16

Myringotomy and Tympanostomy Tube Insertion

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Subject: Myringotomy and Tympanostomy Tube Insertion

Unit: Medical Services

Background:

AOM is responsible for more than 20 million antibiotic prescriptions and more than 24 million office visits annually in the United States and costs approximately 2 to 5.3 billion dollars annually. Because otitis media is the most common reason for antibiotic prescriptions among United States children, it is an important contributor to the problem of antibiotic-resistant bacteria.²

By 24 hours after diagnosis, 61% of children who have AOM have decreased symptoms, whether they receive placebo or antibiotics, and by 1 week, approximately 75% have resolution of their symptoms. It also has been estimated that between 7 and 20 children must be treated with antibiotics for 1 child to derive benefit.³

Based on some research evidence, the American Academy of Pediatrics in 2004 published guidelines “*Criteria for Initial Antibacterial Agents or Observation in Children Who Have Acute Otitis Media*” so that providers would implement a “watchful waiting” for 48 – 72 hours in select patients depending on age, certainty of diagnosis, illness severity, and ready communication/follow up with parents.¹

The spontaneous resolution rate for OME is high. When residual OME occurs after an episode of AOM, more than 75% of cases resolve within 3 months. OME found incidentally has a lower, but still significant, resolution rate.⁴

Clinical Considerations for OME:

- The AAP policy on OME recommends watchful waiting for 3 months after diagnosis because the harm of a persistent OME is slight when compared with possible harm from treatment (antibiotic overuse and resistance). The child might experience a temporary hearing deficit while the effusion persists, but a short-lived effusion should have minimal effect on a child’s language development.
- Children with persistent OME should be re-examined at 3 to 6 month intervals until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.
- When OME persists beyond 3 months or there is moderate to severe hearing deficit, language delay, or developmental delays, the child’s hearing should be evaluated. Children who are **not** identified by developmental surveillance or screening as being at risk are not likely to experience significant language delays from persistent OME. Short-term hearing loss and language delays may result from persistent effusions, but these conditions are likely to resolve without additional management in most children.

Initiated: 10/2008

Reviewed: 11/2008; 03/2009; 9/2009; 9/30/10; 3/27/13; 5/22/14; 1/23/15; 7/11/16

Myringotomy and Tympanostomy Tube Insertion

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Unit: Medical Services

- As long as a low-risk child experiences minimal symptoms and shows no signs of hearing loss, OME can be observed without intervention. In ongoing studies, children with early tympanostomy tube placement (vs. delayed insertion) have not demonstrated any significant effect on developmental progress.⁵
- The current AAP guideline on OME, based on strong research evidence, suggests that children at risk for (or experiencing) developmental delays, experiencing symptoms secondary to the OME (otalgia, vestibular disturbance, hearing loss), or living in a non-enriching environment may benefit from intervention for a persistent OME.
- Candidates for surgery include children with OME lasting 4 months or longer with persistent hearing loss or structural damage to the tympanic membrane or middle ear.
- Adenoidectomy should not be performed unless a distinct indication exists (nasal obstruction, chronic adenoiditis).
- Repeat surgery should consist of adenoidectomy plus myringotomy, with or without tube insertion.
- Tonsillectomy alone or myringotomy alone should not be used to treat OME.

Criteria to Substantiate Medical Necessity for Myringotomy and Tympanostomy

Tube Placement:

- Recurrent acute otitis media (AOM) – 3 distinct episodes of acute otitis media within 6 months or 4 or more distinct episodes within 1 year.
 - Documented evaluation and appropriate treatment
 - Appropriate treatment is defined as use of first or second line antimicrobial agents (Amoxicillin, high-dose Amoxicillin, Amoxicillin/clavulanic acid, Cefdinir) for an appropriate length of time (7 -10 days).
- Documented otitis media with effusion (OME) lasting 3 months or longer with:
 - Documented hearing loss, or
 - Physical abnormality of the tympanic membrane or middle ear structures, or
 - Recurrent or persistent AOM (as defined above) of the same ear, or
 - Significant otalgia requiring multiple PCP or ED visits.
- Other Considerations:
 - Complications of otitis media
 - Meningitis
 - Facial nerve palsy
 - Mastoiditis

Initiated: 10/2008

Reviewed: 11/2008; 03/2009; 9/2009; 9/30/10; 3/27/13; 5/22/14; 1/23/15; 7/11/16

Myringotomy and Tympanostomy Tube Insertion

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Comprehensive Medical and Dental Program Authorization Guideline

Subject: Myringotomy and Tympanostomy Tube Insertion

Unit: Medical Services

- Brain abscess
- Retraction pockets
- Previous history of Myringotomy tube placement
- Cholesteatoma

References:

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Signature on file

Medical Director

7/11/2016

Date

Initiated: 10/2008

Reviewed: 11/2008; 03/2009; 9/2009; 9/30/10; 3/27/13; 5/22/14; 1/23/15; 7/11/16
Myringotomy and Tympanostomy Tube Insertion

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Comprehensive Medical and Dental Program Authorization Guideline

Subject: Occupational, Physical, and Speech Therapy Services

Unit: Medical Services

Initiated: 05/18/10

Reviewed: 1/6/12, 6/19/13, 7/23/14, 7/11/16

Purpose

This guideline is used in the prior authorization process regarding requests for occupational, physical, and speech therapy services, particularly for those children with motor and developmental disabilities who require assistance to adapt to possible life-long limitations of function.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Definitions

Occupational therapy (OT) services are primary care provider (PCP) or attending physician-ordered treatments to improve or restore functions which have been impaired by disability, illness or injury, or which have been permanently lost. OT is intended to improve the member's ability to perform fine-motor, visual-motor, and sensory-processing tasks required for independent functioning.

Physical therapy (PT) is a PCP or attending physician-ordered treatment service to restore or improve gross motor skills, muscle tone, joint or functional mobility impaired by disability, illness, or injury.

Speech therapy (ST) is the medically ordered provision of diagnostic and treatment services in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

Background

Therapy services may be ordered to improve/restore function in a child/youth who has been injured and who has hope of full recovery of function or to assist children with motor and/or developmental disabilities adapt to probable life-long limitations in function. This guideline focuses on the latter group. Many of these children may be Arizona Early Intervention Program (AzEIP)-eligible or be in receipt of services through the Department of Economic Security Division of Developmental Disabilities (DDD).

Initiated: 2/10

Revised: 6/19/13

Reviewed: 6/19/2013, 7/23/2014, 1/23/15, 7/11/16

Therapy Guideline

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Occupational, Physical, and Speech Therapy Services

Unit: Medical Services

The Child Abuse Prevention and Treatment Act (P.L. 104-235), as amended by the Keeping Children and Families Safe Act (P.L. 108-36), requires States to refer a child under the age of three, who is the subject of a substantiated report of child abuse or neglect, for early intervention services available through the Individuals with Disabilities Education Act, Part C. This means all CMDP members are eligible to be referred to AzEIP, the program which delivers early intervention services in Arizona.

A child between birth and three years of age is eligible for AzEIP if he or she has a developmental delay or an established condition that has a high probability of resulting in a developmental delay. A child from birth to three years of age will be considered to exhibit a developmental delay when that child has not reached 50 percent of the developmental milestones expected at his or her chronological age, in one or more of the following domains:

- Physical: fine and/or gross motor/sensory (includes vision and/or hearing)
- Cognitive
- Language/communication
- Social or emotional
- Adaptive (self-help)

CMDP is the primary payer for **medically necessary** therapy services for children in out of home care under three years of age eligible for AzEIP services. AzEIP does not necessarily look at medical necessity in determining who receives therapies through their program. However for CMDP, therapy services **must** be medically necessary in order to be approved. This implies the potential for adaptation and improvement. Once that potential has been realized, or no potential exists, it will be difficult to prove medical necessity.

According to the American Academy of Pediatrics (AAP), there are few hard-and-fast rules for determining medical necessity in this area. Clear documentation of efficacy is elusive. However, AAP has developed the following general guidelines:

- Therapy goals should be specific and measurable and established in partnership with the child's caregivers
- Greater frequency of service may not provide any advantage over routine frequencies
- Long-term therapy may confer no advantage over short-term therapy
- Sensory integration intervention has no science to support its use in children with motor disabilities
- Provision of at-home services with instruction of caregivers is generally indicated

Initiated: 2/10
Revised: 6/19/13
Reviewed: 6/19/2013, 7/23/2014, 1/23/15, 7/11/16
Therapy Guideline

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Occupational, Physical, and Speech Therapy Services

Unit: Medical Services

For CMDP, it is anticipated that part of the therapy process will include education of the out of home placements in overseeing necessary exercises so that they may maintain improvements gained after the medical necessity of ongoing professional services has ceased.

At three years of age when AzEIP eligibility ends, the CHILD FIND program, administered through the public schools, becomes responsible for providing therapy services needed by children in order to attend and succeed in school. CMDP will provide medically necessary therapy services which wrap around school-provided services if it can be shown that CHILD FIND does not provide all services medically needed by the child. Part of this documentation would include a copy of the child's individual education plan (IEP) with a detailed description of the services provided by the school. Failure to pursue medically needed therapy services through CHILD FIND does not constitute medical necessity for CMDP to approve services.

Criteria to Substantiate Medical Necessity:

New referrals for AzEIP eligible children:

- Prescription/order/referral for therapy services by a PCP or attending physician or agreement that AzEIP-recommended services are medically needed. Because of the requirement for 50% delay in one or more areas, most new AzEIP referrals will be medically necessary in the area in which AzEIP has documented at least 50% delay.
- Potential for improvement or need for adaptation in areas of limited physical function at time of initial request
- **Recent**, specific therapist-defined, measurable goals, a recommended frequency of service, and a timeline for achieving those goals, including the anticipated end date of professional services
- A copy of the developmental assessment used in determining eligibility for AzEIP (the developmental assessment may be used to determine medical necessity in lieu of a therapist evaluation **IF** the assessment is very recent and clearly demonstrates medical need for the requested therapy; however a therapist-defined treatment plan is preferable)
- For speech therapy requests, evidence that the child's hearing is normal

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Occupational, Physical, and Speech Therapy Services

Unit: Medical Services

For school-aged children:

- For children three years of age or older, in addition to all the above:
 - Documentation of school-provided services including a copy of the IEP
 - Documentation demonstrating the medical need for services beyond what is provided by the school

For ongoing therapy requests:

- After initial approval, evidence of improvement/adaptation with the potential for future improvement/adaptation:
 - Progress notes and/or updated evaluation showing goals already achieved and new goals to be attained
 - Plan for educating out of home placements in maintaining gains achieved when professional therapy services cease

General criteria:

- Compelling evidence is required to justify a frequency greater than once a week
- Duration approvals will not exceed six months; if therapy is needed beyond the duration of the authorization, a new authorization request is required.
- AzEIP and DDD service coordinators should be notified of approvals/denials when CMDP is aware of their involvement.
- Therapy evaluations that have a standard score of 70 or above are unlikely to be approved as medically necessary. Any score below 70 is defined as “severe delay” and would be considered for approval.

**Comprehensive Medical and Dental Program
Authorization Guideline**

Subject: Occupational, Physical, and Speech Therapy Services

Unit: Medical Services

References:

Arizona Health Care Cost Containment System Medical Policy Manual Chapter 300
Clinical Report: Providing Therapy Services for Children with Motor Disabilities, Linda J.
Michaud, MD, and the Committee on Children with Disabilities, PEDIATRICS Vol.113 No. 6
June 2004.

Signature on file

Medical Director

7/11/2016

Date

Initiated: 2/10
Revised: 6/19/13
Reviewed: 6/19/2013, 7/23/2014, 1/23/15, 7/11/16
Therapy Guideline

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Medically Necessary Orthodontia

Unit: Medical Services

Initiated: 2004

Reviewed: 09/07, 11/05/08, 11/19/09, 01/06/12, 07/18/12, 08/17/12, 09/07/12, 09/27/12, 11/28/12, 05/17/13, 02/26/14, 1/23/15, 7/20/16

Legal Basis:

A.R.S. § 8-512 directs the Department of Economic Security (DES) to provide comprehensive medical and dental care for children in foster care, to ensure medically necessary services are identified and provided.

A.A.C. R6-5-6001 The goal of the Comprehensive Medical/Dental Program (CMDP) for foster children is to provide, in the most cost effective manner, full coverage for those medical and dental services which are necessary to the achievement and maintenance of an optimal level of physical and mental health for children in foster care.

A.A.C. R9-22-215C.4 and R6-5-6006(7) state that Arizona Health Care Cost Containment System (AHCCCS) and CMDP do not pay for cosmetic services.

A.A.C. R9-22-101.B. Definition of Medical Necessity: AHCCCS covers those services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law to:

- a. Prevent death, treat/cure disease, and ameliorate disabilities or other adverse health conditions; and/or
- b. Prolong life.

American Dental Association (ADA) - Definition of Medical Necessity: Care is medically necessary for the purpose of controlling or eliminating infection, pain, and disease; and restoring facial configuration or function necessary for speech, swallowing or chewing.

The Intergovernmental Agreement between AHCCCS and DES for CMDP establishes CMDP as an AHCCCS Health Plan and outlines health plan operational requirements.

Purpose:

The purpose of this guideline is to describe the process used to determine medical necessity for orthodontic care, the documentation needed to make a medical necessity determination and what clinical criteria will be considered prior to authorizing orthodontic care and services.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical and dental research, physician and dentist practice patterns, and

**Comprehensive Medical and Dental Program
Authorization Guidelines**

Subject: Medically Necessary Orthodontia

Unit: Medical Services

health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Medically Necessary Orthodontia

Unit: Medical Services

Considerations for Orthodontia:

Orthodontic services and orthognathic surgery are covered when these services are medically necessary to treat a handicapping malocclusion. Services must be medically necessary, cost-effective and part of an overall treatment plan developed by both the general or pediatric dentist, **and** the member's primary care provider (PCP) through a consultative process. Orthodontic services are not covered when the primary purpose is cosmetic or when not found to be medically necessary.

Comprehensive Orthodontia requires a 24 to 36 month commitment, depending on the severity of the dental condition (malocclusion), the age and cooperation of the child, and the length of time necessary to achieve a satisfactory outcome. During the entire treatment process, the child must have the support of responsible caregivers who will ensure that appointments are kept and excellent oral hygiene is maintained in order to avoid the development of gum disease or dental decay.

Orthodontia involves taking the child to the dental provider a minimum 1-2 times/month over this 24 to 36 month period for routine adjustments to the wires/appliances. Orthodontia can also involve taking the child to the dental provider on an emergent basis when the child experiences pain or experiences problems with the dental appliances or wires.

Orthodontic braces may be uncomfortable and sometimes painful for the child following initial placement or after adjustments. The child must be fully committed and mature enough to handle his/her participation in this long process. The child will have a long list of foods and beverages that should be avoided while he/she is in braces (e.g. nuts, sticky candy, popcorn, pretzels, high sugar juices and soft drinks, etc.).

As a rule, it is very difficult and expensive to attempt to transfer care for orthodontic services from one dental provider to another. It is also difficult to secure ongoing payment for this dental service after the child leaves foster care.

Starting braces in a child who is not a good candidate may be a disservice and could cause harm to the child. The CMDP Dental Consultant must review the referral and all supporting documentation submitted to determine if this child is an appropriate candidate and confirm that the request for orthodontic consultation meets the medical necessity criteria specified in this policy.

Medical Criteria for Orthodontia:

The involvement of the general or pediatric dentist and the PCP are necessary in the determination of orthodontia medical necessity. Due to the relationship of severe malocclusion and compromised health concerns, the PCP involvement and statement is needed in the determination process for orthodontia services. Severe handicapping malocclusion generally involves skeletal discrepancies

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Medically Necessary Orthodontia

Unit: Medical Services

that often compromise swallowing, mastication, breathing and speech. **Documentation from both the dental provider and the PCP is needed** to determine if the existing malocclusion meets the medically necessary criteria for orthodontic care.

Only those services that meet the definition of medical necessity will be considered for treatment.

The following conditions will be considered in determining medical necessity:

- Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services, or
- Trauma requiring surgical treatment in addition to orthodontic services, or
- Significant Skeletal discrepancy involving maxillary and/or mandibular structures

Prior Authorization Process

For comprehensive orthodontic consideration, 2 separate prior authorizations (PAs) need to be completed. The 1st PA is the request for the Pre-Orthodontic Visit (Orthodontia Consult). **IF** this first PA is approved, then the 2nd PA, the request for Comprehensive Orthodontic Treatment can be submitted.

1st Prior Authorization:

Request for Pre-Orthodontic Treatment (Orthodontia Consult) Visit (D8660)

- A) The child must be evaluated by the general or pediatric dentist to determine if there are any reasons justifying medical necessity for a pre-orthodontic visit. The dental provider must complete the *General/Pediatric Dentist Orthodontic Treatment Referral form* to attest to member's treatment services received and current oral health condition.
- B) The child must be evaluated by the Primary Care Physician (PCP) to determine if there are any reasons justifying medical necessity for a pre-orthodontic visit. The PCP must complete the *PCP Statement of Medical Necessity – Orthodontia form* to attest to the physical exam findings which justify medical necessity of a pre-orthodontic visit.
- C) CMDP will then notify the legal guardian to complete the *Consideration Factors for Orthodontic Services form*.
- D) The CMDP Dental Consultant will review: the *General/Pediatric Dentist Orthodontic Treatment Referral form*, the *PCP Statement of Medical Necessity – Orthodontia form*, and the *Consideration Factors for Orthodontic Services* documents and make a determination, as to whether or not sufficient medical necessity exists to authorize an evaluation (pre-orthodontic treatment visit or consultation) by an orthodontic dental provider.

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Medically Necessary Orthodontia

Unit: Medical Services

- E) If CMDP authorizes the Pre-Orthodontic Treatment/Consult Visit, the legal guardian will be notified of this decision and sent a list of CMDP network orthodontic providers from which to choose. If the Pre-Orthodontic Treatment Visit is denied, a Notice of Action (NOA) will be generated and there will be no orthodontic consideration for member.

2nd Prior Authorization:

Request for Comprehensive Orthodontic Treatment (D8070) (D8080) (D8090)

- A) The orthodontic dental provider completes the consultation. If he/she determines that orthodontia may be medically necessary, they must submit the ADA claim form with CDT-15-16 dental procedure codes, Diagnostic Cast (D0470) and the request for Comprehensive Orthodontic Treatment (D8070) (D8080) (D8090).
- B) If comprehensive orthodontic services are being requested, then the provider must submit ALL of the following along with an ADA claim form and codes for the orthodontia:
- | | |
|--------------------------|--|
| 1. Diagnosis | 5. Radiographs |
| 2. Duration of treatment | 6. Photographs |
| 3. Diagnostic Cast | 7. Dentist's Certification of Medical Necessity Form |
| 4. Tracings | |
- C) The CMDP Dental Consultant will review all documentation and make the determination as to whether the request for Comprehensive Orthodontic Treatment sufficiently meets medical necessity. The dental provider and legal guardian will be notified of the approval or denial decision.

Forms:

Form - CMD 1039A Consideration Factors for Orthodontic Services
Form - PCP Medical Necessity
Form – General/Pediatric Dental Ortho Referral

References:

Guide to Children's Dental Care in Medicaid – Department of Health & Human Services, CMS 2004
Arizona Administrative Code, Department of Economic Security – Social Services
Article 60. Comprehensive Medical/Dental Program for Foster Children
R6-5-6005 Definition of Covered Services
R6-5-6006 Exceptions, limitations and exclusions

**Comprehensive Medical and Dental Program
Authorization Guidelines**

Subject: Medically Necessary Orthodontia

Unit: Medical Services

Chapter 400 AHCCCS Medical Policy Manual, Policy 430-12
CMDP Dental & Orthodontia Policy & Procedures

Signature on file
Medical Director
Sara Park, MD

07/20/16
Date

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Palivizumab (Synagis) Administration

Unit: Medical Services

Purpose

This guideline is used in the prior authorization and decision-making process regarding requests for palivizumab (Synagis) administration.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

Respiratory Syncytial Virus (RSV) is one of the leading causes of upper respiratory illness in children during the winter months. RSV infection is characterized by copious muco-purulent discharge and upper airway congestion. In some cases, RSV infection can progress to pneumonia and cause significant hypoxia. Children with chronic medical condition, such as chronic lung disease, cardiac disease, and reactive airway disease, can become severely ill from RSV infection.

Aside from typical preventative measures (hand washing, hygiene, fomite control), an important aspect of RSV infection prevention has been prophylactic vaccination with RSV immunoglobulin. The currently formulated version of RSV immunoglobulin, Palivizumab, is marketed as Palivizumab (Synagis). Palivizumab is an immunoglobulin, providing passive immunity, meaning it does not induce an immune response in the recipient, and must be given on a regular basis (monthly injections) to continue providing protective immunotherapy.

All prescriptions for Palivizumab must have prior authorization.

Criteria to Substantiate Medical Necessity for Palivizumab (synagis) Administration

In evaluating a request for prior authorization of a prescription for Palivizumab, the determination of whether the requested prescription is medically necessary will take into account all of the following:

- Prophylaxis is being prescribed for use during Respiratory Syncytial Virus (RSV) season.
- A maximum of 5 monthly doses of palivizumab may be administered during the RSV season to infants who qualify for prophylaxis in the first year of life. Qualifying infants born during the RSV season will require fewer doses. For example, infants born in January would receive their last dose in March, as protection lasts for a full month.

Initiated: 11/2008

Revised: 11/2008; 12/2009, 2/22/11

Reviewed: 11/2008, 12/2009, 2/22/11, 9/4/2013, 8/19/2014, 1/23/15, 7/11/16

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Palivizumab (Synagis) Administration

Unit: Medical Services

- The infant or child is at risk of developing severe RSV infection as defined by the 2014 American Academy of Pediatrics (AAP) Guidelines on Prevention of RSV Infection.

American Academy of Pediatrics Guidelines for Palivizumab Administration (2014)

Future revisions to the AAP Guidelines on Prevention of RSV Infection will apply when determining medical necessity.

Infants/Children meeting criteria for administration of a **maximum of 5 doses:**

- In the first year of life, palivizumab prophylaxis is recommended for infants born before 29 weeks, 0 days gestation. Palivizumab prophylaxis is not recommended for otherwise healthy infants born at or after 29 weeks, 0 days gestation.
- In the first year of life, palivizumab prophylaxis is recommended for preterm infants with chronic lung disease of prematurity defined as <32 weeks, 0 days gestation **and** a requirement for >21% oxygen for at least 28 days after birth.
- Clinicians may administer palivizumab prophylaxis in the first year of life to certain infants with **hemodynamically** significant heart disease.
- Children with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways **may be considered** for prophylaxis in the first year of life.
- Palivizumab prophylaxis is not recommended in the second year of life **except** for children who require at least 28 days of supplemental oxygen after birth and **who continue to require medical intervention for chronic lung disease of prematurity** (e.g., supplemental oxygen, chronic corticosteroid or diuretic therapy).
- Children less than 24 months of age who will be profoundly immunocompromised during the RSV season **may be considered** for prophylaxis.
- Insufficient data are available to routinely recommend palivizumab prophylaxis for children with cystic fibrosis or Down syndrome.

Please note: Monthly prophylaxis should be discontinued in any child who experiences a break

Initiated: 11/2008

Revised: 11/2008; 12/2009, 2/22/11

Reviewed: 11/2008, 12/2009, 2/22/11, 9/4/2013, 8/19/2014, 1/23/15, 7/11/16

**Comprehensive Medical and Dental Program
Authorization Guideline**

Subject: Palivizumab (Synagis) Administration

Unit: Medical Services

through RSV hospitalization.

References

1. American Academy of Pediatrics: Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. (2014). *PEDIATRICS: Official Journal of the American Academy of Pediatrics*, 134(2), 415-420. Retrieved from <http://pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665>
2. AAP Policy Statement Modified Recommendations for Use of Palivizumab for Prevention of Respiratory Syncytial Virus Infections. *Pediatrics*; Vol 124(6) December 2009
3. Principles and Practices of Pediatric Infectious Diseases, 3rd ed. pp. 1112 – 1117.
4. NICU Nursing Education Department, Maricopa Medical Center

Signature on file
Medical Director

7/11/2016
Date

Initiated: 11/2008
Revised: 11/2008; 12/2009, 2/22/11
Reviewed: 11/2008, 12/2009, 2/22/11, 9/4/2013, 8/19/2014, 1/23/15, 7/11/16

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Pediatric Procedural Sedation

Unit: Medical Services

Purpose

This guideline is used in the decision-making process regarding prior authorization for pediatric procedural sedation for non-invasive or mildly painful procedures.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Goals of Sedation

The goals of sedation in the pediatric patient for diagnostic and therapeutic procedures are to:

- 1) guard the patient's safety and welfare
- 2) minimize physical discomfort and pain
- 3) control anxiety, minimize psychological trauma, and maximize the potential for amnesia
- 4) control behavior and/or movement so as to allow the safe completion of the procedure
- 5) return the patient to a state in which safe discharge to home can safely occur

These goals can best be achieved by selecting the lowest level of sedation with the highest therapeutic index for the procedure (minimal distress for patient) and highest likelihood of success in completing the procedure in a timely fashion.

Each sedation should take into account the type of procedure that will be performed (i.e., painful vs. non-painful) and the age, developmental status, and personality type of the child. Thought should always be given to how a procedure could be accomplished without medication through the use of emotional support and/or distraction techniques.

Definition

Sedation is a medically controlled state of depressed consciousness or unconsciousness. Sedation can be divided into conscious sedation (minimal to moderate), deep sedation, and general anesthesia. In conscious sedation, the patient maintains the ability to respond to external stimulation. In deep sedation, patients are not easily aroused. In general anesthesia, patients are not arousable by stimulation. The table below illustrates how the different levels of sedation may be assessed.

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Pediatric Procedural Sedation

Unit: Medical Services

Sedation Level	Verbal Response	Pain Response	Airway Response	Breathing	Circulation
Anesthetic Overdose	0	0	0	0	0/+
Anesthesia	0	0	0	0/+	++
Deep Sedation	0	+	+	++	+++
Moderate Sedation	+	++	+++	+++	+++++
Minimal Sedation	+++	++++	++++	+++++	+++++
No Sedation	+++++	+++++	+++++	+++++	+++++

The important clinical distinction between these states revolves around the ability of the patient to maintain his or her protective reflexes. The minimal and moderate sedated patient maintains protective reflexes, such as gagging and swallowing, and therefore can keep his or her airway patent without assistance. The deeply sedated patient may lose these reflexes and may not be able to maintain his or her airway. The patient under general anesthesia has lost protective reflexes and is unable to maintain his or her airway.

Procedures Likely to Require Procedural Sedation

- MRI
- Bone Scan
- Skeletal Survey
- Dental Procedures:
 - fearful, anxious patients for whom basic behavior guidance techniques have not been successful;
 - patients cannot cooperate due to a lack of psychological or emotional maturity and/or mental, physical, or medical disability;
 - patients for whom the use of sedation may protect the developing psyche and/or reduce medical risk;
 - patients that are extremely uncooperative, fearful, anxious, or uncommunicative;
 - patients requiring significant surgical procedures;
 - patients for whom local anesthesia is ineffective because of acute infection, anatomic variations, or allergy.

Initiated: 8/2003
 Revised: 4/2006; 1/2007; 11/2007; 03/2009
 Reviewed: 1/6/2012, 7/10/2013, 8/7/13, 6/9/2014, 1/23/15, 7/11/16
 Procedural Sedation

Comprehensive Medical and Dental Program Authorization Guideline

Subject: Pediatric Procedural Sedation

Unit: Medical Services

References:

Maricopa Medical Center Department of Anesthesia Guidelines.

UpToDate Literature Search, October 2008.

Procedural Sedation in the Acute Care Setting. American Academy of Family Physicians, January 2005.

Clinical Policy for Procedural Sedation and Analgesia in the Emergency Department. American College of Emergency Physicians, Annals of Emergency Medicine, 1998; 31:663.

American Academy of Pediatric Dentistry. Guideline on Behavior Guidance for the Pediatric Dental Patient, 2008.

Joint Commission on Accreditation of Healthcare Organizations. Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook. Oakbrook Terrace, Ill: JCAHO; 2006: PC41-PC43.

Signature on File
CMDP Medical Director

7/11/2016
Date

Comprehensive Medical and Dental Program Authorization Guideline

**Subject: Sensory and Auditory Integration Training and Facilitated
Communication for Children**

Unit: Medical Services

Purpose

This authorization guideline is used in the decision-making process regarding requests for auditory integration training (AIT), facilitated communication (FC), and sensory integration (SI) therapy services.

CMDP has determined Sensory Integration Training, Auditory Integration Training, and Facilitated Communication are not medically necessary services for children with autism or developmental delays. Occupational therapy with the use of sensory-based therapies may be acceptable as one of the components of a comprehensive treatment plan. However, healthcare providers and caregivers should be informed that the amount of research regarding the effectiveness of sensory integration therapy is limited and inconclusive. CMDP will consider approving OT that has sensory components imbedded in the treatment plan as long as the overall treatment plan and therapeutic goals are functionally based. If the primary goal of OT Therapy is to address sensory issues with SI therapies, then CMDP cannot consider this as a "medically necessary" service.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

AAP – Committee on Children with Disabilities

The American Academy of Pediatrics (AAP) released a policy statement regarding Auditory Integration Training and Facilitated Communication for Autism in August 1998. The policy states, "Both therapies (AIT and FC) seek to improve communication skills. Currently available information does not support the claims of proponents that these treatments are efficacious. Their use does not appear warranted at this time, except within research protocols." The AAP published a statement of reaffirmation for this policy on May 1, 2006.

AAP – Council on Children with Disabilities

The American Academy of Pediatrics (AAP) released a paper regarding the Management of Children with Autism Spectrum Disorders in November 2007. The policy states: "The efficacy of SI therapy has not been demonstrated objectively. Available studies are plagued by methodological limitations."

**Comprehensive Medical and Dental Program
Authorization Guideline**

**Subject: Sensory and Auditory Integration Training and Facilitated
Communication for Children**

Unit: Medical Services

AAP – The Section on Complimentary and Integrative Medicine and Council on Children with Disabilities

The American Academy of Pediatrics (AAP) released a policy statement regarding Sensory Integration Therapies for Children With Developmental and Behavioral Disorders in June 2012. The policy states, the amount of research regarding the effectiveness of sensory integration is limited and inconclusive.

References:

American Academy of Pediatrics, Committee on Children With Disabilities, Auditory Integration Training and Facilitated Communication for Autism. *Pediatrics* Vol. 102 No. 2 August 1998, pp. 431-433. A statement of reaffirmation for this policy was published on May 1, 2006.

American Academy of Pediatrics, The Council on Children With Disabilities, Management of Children With Autism Spectrum Disorders. *Pediatrics* Volume 120, Number 5, November 2007, pp. 1162-1182.

The American Occupational Therapy Association, The Scope of Occupational Therapy Services for Individuals with Autism Spectrum Disorders Across the Lifespan. Policy Statement 2005.

American Academy of Pediatrics, The Section on Complimentary and Integrative Medicine and Council on Children With Disabilities. *Pediatrics* Volume 129, Number 6, June 2012, pp. 1186-1188.

Signature on File

Medical Director

7/11/2016

Date

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Services for Travel Out-of-Country

Unit: Medical Services

Legal

A.A.C. R6-5-6001 The goal of the Comprehensive Medical/Dental Program (CMDP) for children in out of home care is to provide, in the most cost effective manner, full coverage for those medical and dental services which are necessary to the achievement and maintenance of an optimal level of physical and mental health for children in out of home care.

Purpose

This guideline is used in the prior authorization decision-making process regarding requests for out of the country services.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

Title XIX funds cannot be used to pay for services provided outside of the United States. The assumption is that there would never be a medically necessary reason to travel outside the country.

Guideline

CMDP will not cover services provided outside the United States, as these are deemed not medically necessary. Nor will CMDP pay for services that are required so that the patient can travel out of the United States.

If a child/youth in out-of-home care is planning to travel outside the United States, CPS and the AAG's office must consider all the risks and benefits of this proposed travel. In addition, funding would need to be secured to furnish vaccines, etc. that would be needed prior to such travel and arrangements would need to be made for medical care coverage and transport back to the United States in the event of an accident or onset of severe illness while abroad.

A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC,

Signature on File

Medical Director

7/11/2016

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Criteria for the Extraction of Third Molars

Unit: Medical Services

Legal Basis

A.R.S. § 8-512 directs the Department of Economic Security to provide comprehensive medical and dental care for children in foster care, to ensure medically necessary services are identified and provided.

A.A.C., DES – Social Services, Article 60. Comprehensive Medical/Dental Program for Foster Children R6-5-6001 - The goal of the Comprehensive Medical/Dental Program (CMDP) for Foster Children is to provide, in the most cost effective manner, full coverage for those medical and dental services which are necessary to the achievement and maintenance of an optimal level of physical and mental health for children in foster care.

9 A.A.C. 22, Article 2 - Services or items furnished solely for cosmetic purposes are excluded from Arizona Health Care Cost Containment System (AHCCCS) coverage.

A.A.C. R9-22-101.B. Definition of Medical Necessity: AHCCCS covers those services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law to:

- a. Prevent death, treat/cure disease, and ameliorate disabilities or other adverse health conditions; and/or
- b. Prolong life.

American Dental Association, Definition of Medical Necessity: Care is medically necessary for the purpose of: controlling or eliminating infection, pain, and disease; and restoring facial configuration or function necessary for speech, swallowing or chewing.

Purpose

This guideline is used in the prior authorization decision-making process regarding all requests for extraction of third molars.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical and dental research, physician and dentist practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Criteria for the Extraction of Third Molars

Unit: Medical Services

Third molar extractions

Medically necessary third molar removal is a covered service for CMDP eligible members. The procedure requires prior authorization (PA) by CMDP when performed by a dentist or oral surgeon.

The member's healthcare provider must submit appropriate documentation to substantiate medical necessity. The provider request should include narrative statement, periapical or panoramic x-ray and the identification of the symptomatic tooth/teeth.

According to the American Association of Oral and Maxillofacial Surgeons "Predicated on the best evidence-based data, third molar teeth that are associated with disease, or are at high risk of developing disease, should be surgically managed. In the absence of disease or significant risk of disease, active clinical and radiographic surveillance is indicated" (p. 1). Therefore, CMDP requires such as part of the needed medical documentation for approval of third molar extractions.

All cases of third molar extractions should be individually assessed and the choice of therapy selected based upon the existence of patient pain, local or systemic infection, pathology/cyst, caries or root involvement.

Considerations for Treatment:

- Recurrent pain or discomfort
- Partially erupted tooth where infection is present now or in the recent past
- Partially erupted tooth that will likely not erupt into proper alignment
- second or subsequent pericoronitis
- Unrestorable caries
- Caries in adjacent tooth
- Abscess/Cellulitis
- Disease of follicle including cyst/tumor
- Internal or external resorption of tooth or adjacent tooth
- Periodontal disease
- Chronic cheek biting
- Facilitation of restorative treatment including provision for prosthesis
- Patients with a medical condition when the risk of retention outweighs the potential complications associated with removal (osteoradionecrosis, endocarditis, chemotherapy, organ transplants)

Where a general anesthetic is administered for removal of at least one third molar, consideration can be given for the simultaneous removal of the opposing or contralateral third molar when the risk of retention and a further general anesthetic outweighs the risks associated with removal.

**Comprehensive Medical and Dental Program
Authorization Guidelines**

Subject: Criteria for the Extraction of Third Molars

Unit: Medical Services

**Comprehensive Medical and Dental Program
Authorization Guidelines**

Subject: Criteria for the Extraction of Third Molars

Unit: Medical Services

Reference: “The Management of Impacted Third Molar Teeth,” Statement by the American Association of Oral and Maxillofacial Surgeons Concerning the Management of Selected Clinical Conditions and Associated Clinical Procedures, March 2010.

Citation:

White Papers | AAOMS. (2016). Retrieved from <http://www.aaoms.org/practice-resources/aaoms-advocacy-and-position-statements/white-papers>

Signature on file
Medical Director

7/20/16
Date

Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Vision Therapy (As related to treatment of learning disabilities.)

Unit: Medical Services

Purpose

This guideline is used in the prior authorization decision-making process regarding requests for Vision therapy services.

Vision therapy, as defined by the American Optometric Association, is a treatment plan used to correct or improve specific dysfunctions of the vision system. It includes, but is not limited to, the treatment of strabismus (turned eye), other dysfunctions of binocularity (eye teaming), amblyopia (lazy eye), accommodation (eye focusing), ocular motor function (general eye movement ability), and visual-perception-motor abilities.

Optometric vision therapy is based upon a plan of treatment which encompasses lenses, prisms, occlusion (eye patching), and other materials, modalities, and equipment. (Vision therapy can also be called visual or vision training, orthoptics, eye training, or eye exercises.)

CMDP has determined vision therapy is not a medically necessary service for the treatment of learning disabilities. See below for rationale.

This guideline does not represent a standard of care, nor is it intended to dictate an exclusive course of management. Since medical research, physician practice patterns, and health care technology are continuously evolving, please note that the information contained in this guideline may be updated.

Background

AAP – Committee on Children with Disabilities

The American Academy of Pediatrics (AAP), the American Academy of Ophthalmology (AAO), and the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) released a joint statement regarding Vision Therapy. It states, “Visual problems are rarely responsible for learning difficulties. No scientific evidence exists for the efficacy of eye exercises (vision therapy) or the use of special tinted lenses in the remediation of these complex pediatric developmental and neurologic conditions.” Reading involves the integration of multiple factors related to an individual’s experience, ability, and neurologic functioning.

Statistically, when one looks at a group of children with dyslexia or related learning disabilities, they have the same overall eye health as children without such conditions. Research has shown that the majority of children and adults with reading difficulties experience a variety of problems with language that stem from altered brain function and that such difficulties are not caused by

Initiated: 8/2003

Reviewed: 2/2007; 06/2008; 1/2012; 8/21/13; 6/23/14; 1/23/15; 7/11/16

Vision Therapy (as related to treatment of learning disabilities) Guideline 2016

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Comprehensive Medical and Dental Program Authorization Guidelines

Subject: Vision Therapy (As related to treatment of learning disabilities.)

Unit: Medical Services

altered visual function. Currently, there is no scientific evidence that supports the view that correction of subtle eye defects can alter the brain's processing of visual stimuli.

AAO – Policy Statement

The American Academy of Ophthalmology recommends that children who have learning disabilities should:

- o Receive early comprehensive educational, psychological, and medical assessment
- o Receive educational remediation combined with appropriate psychological and medical treatment
- o Avoid remedies involving eye exercises, filters, tinted lenses, or other optical devices that have no known scientific proof of efficacy.

When children have learning problems that are suspected to be associated with visual defects, the primary care provider may consult the Pediatric Ophthalmologist. If no ocular defect is found, the child needs no further vision care or treatment and should be referred for appropriate medical and special educational evaluation and services.

HAYES Medical Technology Directory

This national directory provides a scientific review of new and existing technologies and rates them A through D (an A rating is the highest) for their effectiveness. HAYES' conclusion regarding Vision Therapy is that "the evidence to support the efficacy of vision therapy for visual dysfunctions and dyslexia and other reading disabilities is generally of poor quality and inconclusive." They give this procedure a C-D rating depending on the diagnosis for which it is used. The C rating is considered "Investigational and/or experimental" and the D rating is considered "Investigational and/or experimental or not efficacious and/or not safe".

References:

American Academy of Pediatrics (AAP): Learning Disabilities, Dyslexia, and Vision: A Subject Review, Committee on Children With Disabilities *Pediatrics* 1998;102;1217-1219
American Academy of Ophthalmology (AAO)
American Association for Pediatric Ophthalmology and Strabismus (AAPOS)
American Optometric Association
Hayes Medical Technology Directory

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Medical Director

Initiated: 8/2003
Reviewed: 2/2007; 06/2008; 1/2012; 8/21/13; 6/23/14; 1/23/15; 7/11/16
Vision Therapy (as related to treatment of learning disabilities) Guideline 2016
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**Comprehensive Medical and Dental Program
Authorization Guidelines**

Subject: Vision Therapy (As related to treatment of learning disabilities.)

Unit: Medical Services

____7/11/2016_____

Date

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Vision Therapy (as related to treatment of learning disabilities) Guideline 2016

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