Based on medical necessity and satisfaction of the criteria below and all other terms of the Mississippi Medicaid Program, this item is available for coverage for:

Coverage is available for:

X Beneficiaries under age 21

Beneficiaries age 21 and over

All beneficiaries (no age restriction)

Beneficiaries who are pregnant

The provider must refer to the current fee schedule for the acceptable codes and fee schedule allowances available under Medicaid.

**The following criteria for coverage apply to cranial molding helmets:**

This item may be submitted for

___ Rental only

_X_ Purchase only

___ Rental for X months, then recertification is required

___ Rental up to the purchase amount or purchase when indicated

This item must be ordered by a pediatric neurosurgeon or pediatric craniofacial surgeon. It is expected that physicians, nurse practitioners, or physician assistants order only items within the scope of their specialty. For example, specialized items such as custom wheelchairs or prosthetics and orthotics should be ordered by specialties such as orthopedics and physicians specializing in rehabilitation. Other items are handled through other specialties.

A cranial molding helmet is a hard plastic outer shell helmet or band with a foam lining that is used to treat plagiocephaly, brachiocephaly, and post operative care of patients with craniosynostosis. The helmet or band is used to remold the head into a symmetrical shape as the baby grows. It allows the flattened areas to round out and prevents the bulging areas from bulging more. The helmet or band does not put pressure on the baby's head. It guides the growth to specific areas to improve the head shape.

The cranial molding helmet device is covered if the following apply:

- there is either progressive asymmetry or no improvement over 3 (three) months of consistent and documented conservative treatment; **and,**

- there is documented evidence of the caregiver being informed that although "back to sleep" is the recommended sleeping position for infants, the baby needs tummy time during periods of wakefulness and observation; **and,**
- there is documented evidence of the caregiver being taught techniques to change the position of the baby's head, encourage head turning and neck stretching exercises for torticollis; **and,**
- a diagnosis of positional (deformational) plagiocephaly is confirmed by a pediatric neurosurgeon or pediatric craniofacial surgeon; **and,**
- the diagnosis of craniosynostosis is eliminated by a pediatric neurosurgeon prior to consideration of molding for a helmet, **or**
- the cranial molding helmet device is going to be used for postoperative care of patients with craniosynostosis

There must be documentation that the caregiver understands the strict rules of application and removal. There must be documentation that the caregiver understands the strict rules for cleaning and maintenance.

**For the item to be considered for children over age one , the prescribing physician must be able to document medical necessity based on the above criteria .**

# HEALTHSYSTEMS OF MISSISSIPPI
# CERTIFICATE OF MEDICAL NECESSITY – CRANIAL MOLDING HELMET

**SECTION A** **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: _____

Medicaid #: _____

Date of Birth: ___/___/___ Age:_____Sex: _____ (M or F)

HT: _____ (inches) WT: _____ (lbs)

Date of last visit: _____

Ordering MD/NP/PA Name (First and Last):

_____

Medicaid ID# or MS License #: _____

Telephone #: (____) _____-_____ Ext. _____

**SECTION B** **CLINICAL INFORMATION**

*(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)*

| DIAGNOSES | ICD-9-CM |
|---|---|
| | |
| | |

**Est. Length of Need (# of Months):** ___1 – 99 *(99 = Lifetime)*

| ANSWERS | CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY |
|---|---|
| Y N D | Does the beneficiary have progressive asymmetry? |
| Y N D | Has the beneficiary improved with consistent and documented conservative treatment over three (3) months? |
| Y N D | Is there documented evidence of the caregiver being informed that although "back to sleep" is the recommended sleeping position for infants, the baby needs "tummy time" during periods of wakefulness and observation? |
| Y N D | Is there documented evidence of the caregiver being taught techniques to change the position of the baby's head, encourage head turning and neck stretching exercises for torticollis? |
| Y N D | Does the beneficiary have a diagnosis of positional (deformational) plagiocephaly, which has been confirmed by a pediatric neurosurgeon or pediatric craniofacial surgeon? |
| Y N D | Has a diagnosis of craniosynostosis been eliminated by a pediatric neurosurgeon prior to the consideration of molding for a helmet? |
| Y N D | Will the cranial molding helmet be used for the postoperative care of a patient with craniostosis? |
| Y N D | Has the beneficiary/caregiver received sufficient training in the appropriate application, removal, cleaning and maintenance of the equipment? |

**PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:**

_____

_____

_____

***The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.***

**SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE**

*A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in Section A of this form. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.*

_____ _____

Signature of Physician / Nurse Practitioner / Physician Assistant Date