Prior Authorization Review Panel
MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
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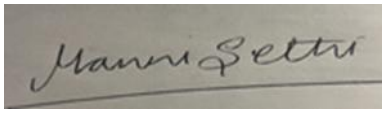
Plan: AmeriHealth Caritas Pennsylvania Community HealthChoices & Keystone First Community HealthChoices	Submission Date: 8/1/2026
Policy Number: CCP.1488	Effective Date: 8/1/2021 Revision Date: 7/1/2026
Policy Name: Medical three-dimensional printing	

Type of Submission:

☐ New Policy	☒ Prior Authorization Policy
☒ Revised Policy*	☐ Base Policy
☐ Annual Review- no revisions	☒ Experimental/Investigational Policy
	☐ Statewide PDL
	☐ Other:

*All revisions to the policy must be highlighted using track changes throughout the document.

Please provide any clarifying information for the policy below:

Name of Authorized Individual (Please type or print): Manni Sethi, MD, MBA, CHCQM	Signature of Authorized Individual: 

Keystone First
Community HealthChoices

Medical three-dimensional printing

Clinical Policy ID: CCP.1488

Recent review date: 7/2026

Next review date: 11/2027

Policy contains: Additive manufacturing; craniofacial surgery; customized implant; knee surgery; maxillofacial surgery; spinal surgery; three-dimensional printing.

Keystone First Community HealthChoices has developed clinical policies to assist with making coverage determinations. Keystone First Community HealthChoices' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by Keystone First Community HealthChoices, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Keystone First Community HealthChoices' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Keystone First Community HealthChoices' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First Community HealthChoices will update its clinical policies as necessary. Keystone First Community HealthChoices' clinical policies are not guarantees of payment.

Coverage policy

Three-dimensional printing (i.e., additive manufacturing) of anatomic structures for surgical planning, implant templating, procedural guidance, or customized implants is investigational/not clinically proven and, therefore, not medically necessary.

Limitations

No limitations were identified during the writing of this policy.

Alternative covered services

No alternative covered services were identified during the writing of this policy.

Background

Medical three-dimensional printing, also called additive manufacturing, produces a three-dimensional object from a digital file of high-quality data collected from multiplanar imaging (Ballard, 2018). Most systems involve separating a digital design file into two-dimensional layers, building a three-dimensional object from raw material one layer at a time, and joining them to the layer directly below. Three-dimensional printing adds material only where necessary (i.e., additive), unlike conventional manufacturing, which cuts and shapes an object from a solid block of material (i.e., subtractive).

A range of methods and materials can produce three-dimensional devices with potential application in patient education and medical education and training. Clinical applications that have the potential to improve patient outcomes and increase economic feasibility include surgical planning, intraoperative guidance, and

individualized implants (Kim, 2016). In addition, three-dimensional printing with cells (bioprinting) may allow for regenerative scaffolds and cell-specific replacement tissue and organs.

Three-dimensional devices are classified as implantable or nonimplantable, and patient-matched (or patient-specific) or non-patient-matched (Di Prima, 2016). The term “patient-matched” is often used interchangeably with the term “custom,” but, for regulatory purposes, they are not synonymous (U.S. Food and Drug Administration, 2017). Custom devices may be exempt from premarket approval requirements and review if they meet all of the following criteria:

- Are created or modified to comply with the order of an individual physician or dentist.
- Do not exceed five units per year.
- Are reported by the manufacturer to the U.S. Food and Drug Administration for devices manufactured and distributed under section 520(b) of the Food, Drug, and Cosmetic Act.

Patient-matched devices do not automatically meet all of these requirements. Patient-matched devices are typically based on an existing, standardized template model that is matched to a patient with normal bone or joint anatomy using medical imaging (U.S. Food and Drug Administration, 2017).

Findings

Guidelines

The Radiological Society of North America 3D Printing Special Interest Group guidelines recommend the use of three-dimensional printing for several specific clinical scenarios. For congenital heart disease, three-dimensional printing is highly recommended, with a rating of 7 to 9, for preoperative planning, particularly in complex cases such as septal defects and transposition of the great arteries, as it can significantly reduce operation and cardiopulmonary bypass time (Chepelev, 2018). In craniomaxillofacial pathologies, three-dimensional printing is advised for both trauma and congenital malformations, aiding in both functional and aesthetic restoration, with differentiation between simple and complex cases (Chepelev, 2018).

For musculoskeletal pathologies, three-dimensional printing is recommended for fractures, chronic osseous abnormalities, and preoperative planning, enabling the creation of custom implants and surgical guides to improve surgical outcomes and reduce operating time (Chepelev, 2018). Vascular pathologies, especially complex aortic aneurysms and dissections, benefit from three-dimensional printing for preoperative planning and simulation, aiding in device selection and understanding complex anatomy. In genitourinary pathologies, three-dimensional printing is useful for complex kidney tumors and other urological conditions, enhancing anatomical comprehension and surgical planning to improve patient outcomes (Chepelev, 2018). Lastly, for breast pathologies, three-dimensional printing aids in depicting the extent of disease and planning oncologic and reconstructive surgeries, potentially reducing operating time and improving patient outcomes (Chepelev, 2018).

An expert consensus statement on clinical translation of three-dimensional printed patient-specific bone implants emphasized standardized terminology, preclinical testing, multicenter studies, pilot trials before larger studies, and clearly defined target populations. The statement supports evidence development but does not establish clinical effectiveness (Laubach, 2025).

A multidisciplinary consensus statement on medical three-dimensional printing within health care facilities issued 25 statements addressing general practice, quality and safety, government relations, and economics. The statement emphasized validated image acquisition and segmentation, file verification, quality management systems, and institutional oversight. These recommendations support operational standardization but do not establish medical necessity (Rybicki, 2026).

Systematic reviews and meta-analyses

For this policy, we included evidence from systematic reviews and meta-analyses, which are discussed below. The clinical applications of three-dimensional printing fall into two general categories: procedural uses and material uses. We considered the role of three-dimensional printing in surgical planning, implant templating, procedural guidance, and customized implants. The most common clinical applications represented in the literature are craniomaxillofacial reconstruction, orthopedic repair and replacement, and spinal surgery, which are discussed below. Other emerging specialty areas include surgery for congenital heart defects (Lau, 2019), colorectal surgery (Emile, 2019), and nephrectomy (Jiang, 2020; Sun, 2018).

While the evidence from systematic reviews and meta-analysis confirms the expanding interest and role in three-dimensional printing across multiple disciplines, it also confirms the paucity of high-quality research supporting the medical necessity of three-dimensional printed materials and procedural uses at this time. Pre-surgical three-dimensional models and anatomic guides may improve intraoperative metrics and surgical outcomes by making the procedure safer and more predictable. Compared to off-the-shelf products, customized three-dimensional printed materials may offer improved fit and functional outcomes and the ability to address unique and complex anatomy.

However, the research has failed to clearly delineate a clinical advantage of three-dimensional printing relative to conventional procedures and materials, which would require higher quality comparative trials. Limitations to the research include the diversity of workflows and applications involving different materials, printers, and testing methods. In addition, the custom-made nature of implants prevents meaningful comparison of three-dimensional printed interventions to conventional interventions and off-the-shelf products.

In 2025 and 2026, newly identified systematic reviews and consensus statements continued to show procedural efficiency benefits in selected complex surgical settings. The evidence remains limited by small samples, heterogeneous indications, variable printing methods, inconsistent follow-up, and limited cost-effectiveness evidence.

Three-dimensional printing provides an opportunity to customize upper limb prostheses, but the evidence consists of case studies and small case series that lack external validity and avoidance of bias. The evidence fails to demonstrate statistically significant improvements in comfort, functionality, durability, and long-term effects on patient quality of life compared to conventional prostheses (Diment, 2018).

A systematic review (Francoisse, 2021) examined pediatric applications of three-dimensional printing from 139 low-quality observational studies (n = 508 total pediatric participants). Six of the studies compared three-dimensional printing to conventional methods for procedural outcomes. Three-dimensional printed contour models, guides, splints, and implants were at least equivalent to conventional methods, with shorter operating time and fluoroscopy exposure, more accurate hardware placement, and fewer complications. The results highlighted the potential of three-dimensional printing to address challenges unique to the pediatric population, such as compact anatomy, unique congenital variants, greater procedural risk, and growth over time.

Craniomaxillofacial surgery

In oral and craniomaxillofacial surgery, three-dimensional printed bone models were mainly used as training or simulation models for tumor removal, bone reconstruction, or complex deformity (Meglioli, 2020). In mandibular reconstruction, a systematic review and meta-analysis (Serrano, 2019) found that the most frequently reported clinical outcomes were a reduction in operating time (reported in 35.7% of studies) and an improvement in the final aesthetic result (28.6%).

Focusing specifically on orbital surgery, a 2024 review of 12 investigations (n = 132) demonstrated that patient-specific, three-dimensionally printed models, guides, and implants significantly improve quantitative outcomes. For fracture repairs, implants pre-contoured on printed templates reduced mean operating times by approximately 30 minutes compared to standard methods, with postoperative diplopia and enophthalmos rates

below 12%. Reconstructions for tumors and congenital defects achieved near-symmetrical orbital volumes and high aesthetic satisfaction. These findings support 3D printing as a valuable adjunct for streamlining workflows and heightening surgical accuracy in orbital surgery (Michelutti, 2024). Similarly, a large 2022 meta-analysis of 906 participants found that groups using 3D-printed orbit models were less likely to have postoperative diplopia ($P < .001$) and enophthalmos ($P < .001$); however, the authors noted the contribution of 3D printing alone to these improvements remains unclear due to a lack of controlled studies (Murray-Douglas, 2022).

For nasal prostheses, evidence from three systematic reviews (Crafts, 2017; Martelli, 2016; Tack, 2016) consist of animal modeling studies, technical feasibility reports, and a low-quality retrospective case series and case reports. Currently, most otolaryngologic applications for three-dimensional printing are at preliminary stages of development, as manufacturing processes continue to be refined. Three-dimensional printing can produce accurate, patient-specific nasal prostheses, which may be particularly helpful to individuals with unique anatomies, but their superiority to conventionally manufactured prostheses has not been demonstrated. Reducing malalignment does not automatically result in improved clinical outcomes (e.g., better fit, comfort, or satisfaction), and long-term revision rates (i.e., prosthesis survival) have not been reported. Mismatched skin tone is a major limitation of three-dimensionally printed facial prostheses. Whether the additional upfront costs of three-dimensional printing result in lower overall costs of care is unclear. Beyond reconstruction, evidence also addresses the use of 3D printing for dental prosthetics, with a 2022 systematic review of 16 studies determining that additive manufacturing for implant-supported fixed prostheses demonstrates similar accuracy as conventional and computer-aided design / computer-aided manufacturing techniques in vitro (Rutkunas, 2022).

Breast Reconstruction

In the realm of soft tissue procedures, recent evidence details how 3D printing can enhance the complex planning and execution of autologous breast reconstruction. A review of 13 studies showed that patient-specific 3D models improved outcomes; for instance, vascular guides depicting deep inferior epigastric perforator anatomy increased successful flap harvests to 90% from 58.6% and reduced intramuscular dissection time. Furthermore, volumetric breast molds achieved a coefficient of determination of 0.99 between predicted and actual flap weights, helping surgeons reproduce native breast symmetry with high fidelity. With complication rates matching those of conventional imaging, these findings underscore the technology's safety and effectiveness in improving anatomical accuracy and operative efficiency, though further trials are needed to confirm patient-centered and economic benefits (Carrion, 2024).

Orthopedics

Three-dimensional (3D) printing has several clinical applications in orthopedics, including surgical planning, implant templating, and the anatomical assessment of pathologies. Increasingly, custom-made, 3D-printed, patient-specific metal implants and instruments are being studied for complex procedures such as pelvic oncologic resections and revision hip arthroplasties (Goodson, 2019).

Multiple systematic reviews and meta-analyses suggest that 3D printing-assisted preoperative planning improves intraoperative metrics when compared to conventional methods. For instance, in cases of tibial plateau fractures, a meta-analysis of 1,074 patients found that 3D-assisted surgery significantly reduced operation time, blood loss, and fluoroscopy use (Assink, 2021). Similarly, for acetabular fractures, 3D printing-assisted surgery decreased operation time by an average of 38.8 minutes and blood loss by 259.7 mL, with traditional surgery being 47% less likely to result in good to excellent hip function (Cao, 2021). This trend of improved intraoperative efficiency, including reduced operative time, blood loss, and fluoroscopy use, has also been noted in foot and ankle fracture surgeries (Wood, 2022).

Despite these intraoperative benefits, the effect of 3D printing on clinical outcomes, such as fracture healing time, postoperative joint function, and complication rates, is not yet well-defined. The variability in these results

is likely influenced by factors like the location and complexity of the fracture (González-Alonso, 2020; Wang, 2020; Xie, 2018). Consequently, researchers across all analyses recommend large-sample randomized controlled trials to definitively establish the superiority of 3D printing-assisted orthopedic surgery. A health technology assessment (DEFACTUM, 2019) of six randomized controlled trials and two systematic reviews found very low-quality to low-quality evidence supporting the superiority of three-dimensional printed guides or implants over standard instrumentation with respect to malalignment and deviation in adults undergoing total knee arthroplasty for osteoarthritis or rheumatoid arthritis. The limitations of the evidence were a high risk of bias and imprecision of the estimates in the included studies. The authors called for higher quality evidence to validate these findings. Further exploring hip surgery, a 2024 systematic review of 62 studies (n = 1,065) highlighted the potential benefits of 3D printing for surgical precision, reduced operation time, and minimized radiation exposure across various applications, including osteotomies and arthroplasties, while also emphasizing the need for more high-quality, randomized studies to conclusively establish these advantages (Aguado-Maestro, 2024).

Seven comparative studies of three-dimensional assisted techniques for complex periarticular fractures included 20 to 70 participants per study. Five studies were randomized controlled trials, one was a prospective cohort study, and one was a retrospective cohort study. Three-dimensional approaches included printed models, surgical guides, and patient-specific implants. Most studies reported shorter operative time, less blood loss, fewer fluoroscopy exposures, or improved reduction measures. Functional outcomes were generally similar or modestly improved. Overall risk of bias was low in three studies, moderate in three, and serious in one. No formal cost-effectiveness analysis was reported (Gong, 2025).

Clinical translation evidence for three-dimensional printing in orthopedic trauma reported outcome-specific participant totals, including operative time in 12 studies (n = 485 participants), reduction quality in 15 studies (n = 672 participants), functional outcomes in 13 studies (n = 548 participants), and complications in 10 studies (n = 412 participants). Three-dimensional printing was associated with improved intraoperative metrics and reduction quality. Interpretation was limited by high heterogeneity, mostly retrospective evidence, variable follow-up, and inconsistent outcome definitions (Long, 2025).

Orthopedic oncology.

Three-dimensional printing in orthopedic sarcoma management was evaluated in 20 studies (n = 296 participants). Most studies were retrospective case series or technical reports, and only two were comparative cohort studies. At least 14 of 18 studies reporting margin status achieved R0 resections in 90% or more of cases. Functional outcomes were commonly reported with weighted pooled Musculoskeletal Tumor Society scores of approximately 23 to 24 out of 30. Complications occurred in 66 of 296 participants, most commonly wound morbidity and infection. The evidence remains limited by small samples, heterogeneous tumor sites, and limited long-term survivorship data (Elgamal, 2025).

Spinal surgery

Spinal implants fall into two categories: fusion (cages, plates with screws, rods with hooks, and pedicle screws) and non-fusion (artificial discs and expandable rods). Medical-grade titanium and polyether ether ketone are widely used for conventional off-the-shelf implants. Three-dimensional printed implants can be designed for complex tumor pathology and atypical bone defects that are considered difficult to treat or that have additional features, such as preplanned screw trajectories or conformities. In an appropriately selected patient, three-dimensional printed patient-specific spinal implants may improve outcomes in terms of surgical efficiency, stability, and potential osseointegration. Randomized controlled trials are needed to confirm these findings.

Two systematic reviews compared the safety and efficacy of three-dimensional printed patient-specific and off-the-shelf devices (Burnard, 2020; Wallace, 2020). The evidence consists of case reports and case series focused on patient-specific titanium implants for anatomically complex cases. Three-dimensional printed products appear

safe with positive subjective feedback from surgeons and patients. However, the clinical and radiographic outcomes, particularly long-term data, are still uncertain.

Another systematic review of adults with spinal deformity (Lopez, 2020) compared the effects of using a three-dimensional printed drill guide template with not using such a template. The use of the template was associated with higher screw placement accuracy across 22 studies (96% versus 81.5%, P < .001), lower operative duration (272 versus 258 minutes, P < .05), and similar perioperative blood loss (924.6 mL versus 935.6 mL, P = .058). A three-dimensional printed drill guide template had a favorable deformity correction rate (n = 245 participants, 72.5%). Influential variables were the types, materials, and manufacturing costs and times of three-dimensional printed technology.

A systematic review of three-dimensional printing in spine surgery included 105 studies (n = 2,088 participants). Patient-specific drill guides were the most common application, followed by anatomic models and customized implants. Most studies reported shorter operative time or satisfactory clinical outcomes, but the evidence was largely small and nonrandomized. Cost reporting was inconsistent. Among 60 studies reporting cost, 52 reported increased cost and eight reported savings. Larger randomized studies are needed (Hajnal, 2025).

Fused deposition modeling and fused filament fabrication were evaluated in 35 studies of surgery and traumatology. These methods were described as accessible and relatively low cost for point-of-care models, training, and procedural planning. The evidence was largely qualitative because indications, materials, printing methods, and outcomes varied across studies (Chrz, 2026).

In 2025, we revised the findings section thematically and added several new references (Carrion, 2025; Hajnal, 2025; Michelutti, 2024). No policy changes were warranted.

In 2026, we added systematic reviews and consensus statements addressing three-dimensional printing for orthopedic trauma, orthopedic sarcoma, spine surgery, fused deposition modeling, patient-specific bone implants, and health care facility quality processes; the evidence supported selected procedural efficiency benefits but did not warrant a coverage change (Chrz, 2026; Elgamal, 2025; Gong, 2025; Laubach, 2025; Long, 2025; Rybicki, 2026).

References

On June 11, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “three dimensional," “printing,” “additive manufacturing,” and “printing, three dimensional” (MeSH). We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

7/2021: initial review date and clinical policy effective date: 8/2021

7/2022: Policy references updated.

7/2023: Policy references updated.

7/2024: Policy references updated.

7/2025: Policy references updated.

7/2026: Policy references and findings updated.

Related codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1488 .This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code description
0559T	Anatomic model three-dimensionally printed from image data set(s), first component.
0560T	Each additional component.
0561T	Anatomic guide three-dimensionally printed and designed from image data set(s), first guide.
0562T	Each additional guide.
1030T-1035T	Digital three-dimensional modeling, simulation, and computational analysis codes, if the policy scope includes digital surface mesh services.
C8001	Three-dimensional anatomical segmentation imaging for preoperative planning.
G0566	Three-dimensional image generation used in surgical planning and navigation for placement of implants and devices in the spine and pelvis.