Plagiocephaly and Craniosynostosis Treatment

Policy Number: 2021T0031V
Effective Date: July 1, 2021

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Related Commercial Policies
- Cosmetic and Reconstructive Procedures
- Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements

Community Plan Policy
- Plagiocephaly and Craniosynostosis Treatment

Coverage Rationale

Cranial Orthotic Devices are proven and medically necessary for treating infants following craniosynostosis surgery or for nonsynostotic (nonfusion) deformational or positional plagiocephaly. For medical necessity clinical coverage criteria, refer to the InterQual” 2021, Apr. 2021 Release, CP: Durable Medical Equipment, Orthoses, Cranial Remodeling.

Click here to view the InterQual” criteria.

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

<table>
<thead>
<tr>
<th>CPT/HCPCS Codes*</th>
<th>Required Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Treatment</td>
<td></td>
</tr>
</tbody>
</table>
| 21175 | Medical notes documenting the following:  
  - History of medical conditions requiring treatment or surgical invention which includes all of the following:  
    - To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment  
    - Recurrent or persistent functional impairment caused by the abnormality  
  - Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment  
  - Physician plan of care with proposed procedures and whether this request is part of a staged procedure; indicate how the procedure will improve and/or restore function |
| Cranial Orthosis |
| L0112, S1040 | Provide the following:  
  - Current prescription from physician |
### Required Clinical Information

#### Cranial Orthosis

- Reason for the orthotic
- Diagnosis
- Physical exam related to support the need of the orthotic; include the neurological, circulatory, skin and musculoskeletal examination that supports the request
- Orthotist notes to include the following:
  - Equipment quote with billing codes and cost
  - Reason for the orthotic
  - Cephalic index
  - Anthropometric Measurements
- Date and type of injury/ surgery, if applicable

For a replacement request, provide medical notes documenting:

- Age of current orthotic
- Reason for replacement

*For code descriptions, see the Applicable Codes section.

### Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

#### CPT Code

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21175</td>
<td>Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)</td>
</tr>
</tbody>
</table>

*CPT® is a registered trademark of the American Medical Association*

#### CDT Code

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5924</td>
<td>Cranial prosthesis</td>
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</tbody>
</table>

*CDT® is a registered trademark of the American Dental Association*

#### HCPCS Code

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L0112</td>
<td>Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated</td>
</tr>
<tr>
<td>L0113</td>
<td>Cranial cervical orthotic, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>S1040</td>
<td>Cranial remodeling orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)</td>
</tr>
</tbody>
</table>

### U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Cranial orthoses are classified by the FDA as Class II devices. This classification requires special controls, including prescription use, biocompatibility testing, and labeling (contraindications, warnings, precautions, adverse events, and instructions for physicians and parents). They are intended for medical purposes to apply pressure to prominent regions of an
Infant's cranium in order to improve cranial symmetry and/or shape in infants from 3 to 18 months of age, with moderate to severe nonsynostotic positional plagiocephaly, including infants with plagiocephalic-, brachycephalic-, and scaphocephalic-shaped heads. The FDA has approved a large number of cranial orthoses. Additional information, under product code MVA, is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed November 19, 2020)

Policy History/Revision Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Changes</th>
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</thead>
<tbody>
<tr>
<td>07/01/2021</td>
<td><strong>Coverage Rationale</strong></td>
</tr>
<tr>
<td></td>
<td>● Replaced reference to “InterQual® 2020” with “InterQual® 2021”</td>
</tr>
<tr>
<td></td>
<td><strong>Supporting Information</strong></td>
</tr>
<tr>
<td></td>
<td>● Archived previous version 2021T0031U</td>
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Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.