Plagiocephaly and Craniosynostosis Treatment (for Nebraska Only)

Policy Number: CS095NE.T
Effective Date: December 1, 2025

Instructions for Use

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Related Policies

- Cosmetic and Reconstructive Procedures (for Nebraska Only)
- Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Nebraska Only)

Application

This Medical Policy only applies to the State of Nebraska.

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® CP: Durable Medical Equipment, Orthoses, Cranial Remodeling.

Click here to view the InterQual® criteria.

For surgical treatment to repair craniosynostosis (CPT code 21175), refer to the Medical Policy titled Cosmetic and Reconstructive Procedures (for Nebraska Only).

For repair or replacement of cranial orthoses, refer to the Medical Policy titled Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Nebraska Only).

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

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 federal, state, or contractual requirements 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.

CDT Code	Description
D5924	Cranial prosthesis

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HCPCS Code	Description
L0112	Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated
L0113	Cranial cervical orthotic, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment
S1040	Cranial remolding orthotic, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)

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 August 29, 2024)

Policy History/Revision Information

Date	Summary of Changes

12/01/2025	**Medical Records Documentation Used for Reviews**
	• Removed reference link to the guidelines titled *Medical Records Documentation Used for Review*
	• Added language to indicate:
	  ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services
	  ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures
	  ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request
	Supporting Information
	• Archived previous policy version CS095NE.S

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The 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.