Plagiocephaly and Craniosynostosis Treatment

Policy Number: CS095.O
Effective Date: July 1, 2022

Instructions for Use

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Related Community Plan Policies

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

Commercial Policy

- Plagiocephaly and Craniosynostosis Treatment

Application

This Medical Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	Plagiocephaly and Craniosynostosis Treatment (for Indiana Only)
Kentucky	Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only)
Louisiana	Plagiocephaly and Craniosynostosis Treatment (for Louisiana Only)
Nebraska	Plagiocephaly and Craniosynostosis Treatment (for Nebraska Only)
New Jersey	Plagiocephaly and Craniosynostosis Treatment (for New Jersey Only)
North Carolina	Plagiocephaly and Craniosynostosis Treatment (for North Carolina Only)
Pennsylvania	Plagiocephaly and Craniosynostosis Treatment (for Pennsylvania Only)
Tennessee	Plagiocephaly and Craniosynostosis Treatment (for Tennessee Only)

Coverage Rationale

Cranial orthotic devices are proven and medically necessary for treating infants following craniosynostosis surgery or for non-synostotic (non-fusion) 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.

Documentation Requirements

Surgical Treatment (CPT 21175)

Medical notes documenting the following, when applicable:

- 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 (HCPCS S1040)

Initial Request

Medical notes documenting the following, when applicable:

- Current prescription from physician
- 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, as well as presence or absence of torticollis
- At least one of the following:
  - Cranial vault asymmetry index (CVAI)
  - Cephalic index (CI)
  - Transcranial diameter difference (TDD)
  - Cranial vault asymmetry (CVA) Children's Healthcare of Atlanta (CHOA) level

  Note: For more details about the definition of these measurements, refer to the InterQual criteria informational notes.
- Documentation of treatments tried, failed, or contraindicated. Include the dates and reason for discontinuation, including:
  - Repositioning
  - Physical or occupational therapy
- Orthotist notes to include the following:
  - Equipment quote with billing codes and cost
  - Reason for the orthotic
  - Anthropometric measurements
- Date and type of injury/surgery, if applicable
  - Plan to treat torticollis with cranial orthosis

Replacement Request

Medical notes documenting the following, when applicable:

- Age of current orthotic
- Reason for replacement
- Adjustments/modifications to current cranial helmet if applicable
- Compliance with wear

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.

CPT Code	Description
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)

CDT Code	Description
D5924	Cranial prosthesis

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 orthosis, 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 non-synostotic 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 23, 2021)

Policy History/Revision Information

Date	Summary of Changes
07/01/2022	Application *Mississippi* • Updated language to indicate this Medical Policy applies to the state of Mississippi (retired state-specific policy version) Supporting Information • Archived previous policy version CS095.N

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.