Plagiocephaly and Craniosynostosis Treatment (for Tennessee Only)

Policy Number: CS095TN.M
Effective Date: July 1, 2021

Instructions for Use

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Application

This Medical Policy applies to Medicaid only plans in the state of Tennessee.

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

Surgical Treatment (CPT 21175)

Provide 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 (HCPCS L0112 and S1040)

Initial Request

Provide medical notes documenting the following:

- 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
- 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

Replacement Request

Provide medical notes documenting the following:

- Age of current orthotic
- Reason for replacement

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 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)

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) for plagiocephaly and craniosynostosis treatments. Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) exist; see the LCDs/LCAs for Cosmetic and Reconstructive Surgery. (Accessed November 5, 2020)

Policy History/Revision Information

Date	Summary of Changes
07/01/2021	**Coverage Rationale** • Replaced reference to "InterQual® 2020" with "InterQual® 2021" **Supporting Information** • Archived previous policy version CS095TN.L

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.