# Plagiocephaly and Craniosynostosis Treatment

**Policy Number**: CS095.R
**Effective Date**: January 1, 2024

➲ 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 | None |
| Kentucky | Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only) |
| Louisiana | Plagiocephaly and Craniosynostosis Treatment (for Louisiana Only) |
| New Jersey | Plagiocephaly and Craniosynostosis Treatment (for New Jersey Only) |
| New Mexico | Plagiocephaly and Craniosynostosis Treatment (for New Mexico Only) |
| North Carolina | Plagiocephaly and Craniosynostosis Treatment (for North Carolina Only) |
| Ohio | Plagiocephaly and Craniosynostosis Treatment (for Ohio 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 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 repair or replacement of cranial orthoses, refer to the Medical Policy titled Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements.

## 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


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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 |

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

| 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 July 26, 2023)

# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 07/01/2024 | **Application**<br>***New Mexico***<br>• Added language to indicate this policy does not apply to the state of New Mexico; refer to the state-specific policy version |
| 01/01/2024 | **Applicable Codes**<br>• Revised description for HCPCS code S1040<br>**Supporting Information**<br>• Archived previous policy version CS095.Q |

# 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.


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