Plagiocephaly and Craniosynostosis Treatment

Policy Number: SURGERY 067.27
Effective Date: January 1, 2025

➲ Instructions for Use

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Related Policies

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

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 Clinical Policy titled Cosmetic and Reconstructive Procedures.

For repair or replacement of cranial orthoses, refer to the Clinical Policy titled Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements.

Medical Records Documentation Used for Reviews

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. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the protocol titled Medical Records Documentation Used for Reviews.

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 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

HCPCS Code	Description
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
01/01/2025	**Medical Records Documentation Used for Reviews** *(previously titled Documentation Requirements)* • Replaced list of *Required Clinical Information* with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews **Supporting Information** • Archived previous policy version SURGERY 067.26

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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 Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

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