



Cranial Orthosis for Treatment of Craniosynostosis and Severe Plagiocephaly and Brachycephaly

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Policy

The Medical Management Department reviews referral requests for authorization of cranial orthosis for treatment of Craniosynostosis and Severe Plagiocephaly and Brachycephaly.

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

A. Documentation Required:

To facilitate the authorization process, referral requests must include **ALL** the following:

1. The cranial orthosis is prescribed by a pediatric neurosurgeon, craniofacial surgeon, plastic surgeon, or APP who works directly with these surgeons.
2. Documentation of anthropometrics measurements via 3D surface imaging and/or stereophotogrammetry.
3. Documentation of conservative therapies tried, for example, physical therapy and repositioning therapy.
4. Documentation that any potential neuromuscular influences have been identified and treated.

B. Criteria for Medical Necessity:

1. Cranial orthosis/helmet therapy is considered medically necessary if **ONE** of the following criteria are met:

- a. Cranial orthosis/remodeling band (or helmet) is considered medically necessary following surgical correction of craniosynostosis; **OR**
- b. Cranial orthosis/remodeling band (or helmet) is considered medically necessary for treatment of plagiocephaly or brachycephaly when initiated between 3-12 months of age and utilized up to 18 months of age when **BOTH** the following criteria are met:
 - i. Patient is aged 3-8 months and has failed a two-month trial of repositioning and/or physical therapy; **OR** Patient is aged 8-12 months at the time of initial evaluation of the deformity (no trial of repositioning or physician therapy is required); **AND**
 - ii. Cranial asymmetry as shown by **ONE** of the following measurements:
 - 1) Cephalic Index (CI) that is 2 or more standard deviations above or below the mean measurements based on age and gender of the child; **OR**
 - 2) Cranial Vault Asymmetry (CVA), skull based asymmetry or orbitotragial depth ≥ 10 mm

C. Indications Considered Experimental, Investigational or not Medically Necessary: *(Not an all-inclusive list):*

1. Children under 3 months of corrected age (history of prematurity) or over 18 months of corrected age.
2. Child has unshunted hydrocephalus.

CPT/HCPCS Codes

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)

References:

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Goh JL, Bauer DF, Durham SR, Stotland MA. Orthotic (helmet) therapy in the treatment of plagiocephaly. Neurosurg Focus. 2013;35(4):E2.

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