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Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses Corporate Medical Policy

File Name: Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses
File Code: 1.01.VT11
Origination: 11/2011
Last Review: 08/2020
Next Review: 08/2021
Effective Date: 04/01/2021

Description

Cranial orthoses involve an adjustable helmet or band that progressively molds the shape of the infant cranium by applying corrective forces to prominences while leaving room for growth in the adjacent flattened areas. A cranial orthotic device may be used to treat postsurgical synostosis or positional plagiocephaly in pediatric patients.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

[Attachment I- CPT® code table & instructions](#)

[Attachment II- ICD-10-CM codes](#)

When a service may be considered medically necessary

The use of an adjustable cranial orthosis is considered **medically necessary** as part of the post-operative management of craniosynostosis.

The use of an adjustable cranial orthosis as a treatment of persistent plagiocephaly or brachycephaly without synostosis may be considered medically necessary when **ALL** of the following conditions have been met:

1. Patient is at least 3 months of age but not greater than 18 months of age; **AND**
2. Marked asymmetry has not been substantially improved following conservative

therapy of at least 2 months duration with cranial repositioning therapy (with or without physical therapy). *Note:* Due to the mobility of children > 4 months of age, repositioning therapy is not effective and thus, a trial of repositioning is not indicated; **AND**

3. Asymmetry of the cranial base as documented by any of the following:
 - *Skull Base Asymmetry:* At least 6 mm right/left discrepancy measured subnasally to the tip of the tragus (cartilaginous projection of the auricle at the front of the ear); or
 - *Cranial Vault Asymmetry:* At least a 8 mm right/left discrepancy, measured from the frontozygomatic point (identified by palpation of the suture line above the upper outer corner of the orbit) to the contralateral euryon, defined as the most lateral point on the head located in the parietal region;
 - *Asymmetry of the orbitotragial distances,* as documented by at least a 4 mm right/left asymmetry measured from the lateral aspect of orbit to tip of ipsilateral tragus.

The custom molded orthotic is designed to fit a child's head for 2-4 months. A second helmet or band may be required if the asymmetry has not resolved or significantly improved after 2-4 months.

When a service is considered investigational

The use of an adjustable cranial orthosis is considered **investigational** for all other indications not outlined above.

Reference Resources

1. BCBSA Policy 1.01.11 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses. Last reviewed August 2020.

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

11/2011	New policy. Coder reviewed and approved codes.
02/2014	ICD-10 remediation only. RLJ
08/2015	No language updates. No coding changes. RLG
06/2017	Minor grammar changes. Policy statement remains unchanged. Updated references.
09/2018	Reviewed and updated references no changes to policy statements.

08/2020	Policy statement changed to include medical necessity for brachycephaly without synostosis. Introduction and references simplified.
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Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors Date Approved

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Chief Medical Officer

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Attachment I HCPCS Codes and Instructions

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
HCPCS	L0112	Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated	See prior approval list for instructions
HCPCS	L0113	Cranial cervical orthosis, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment	See prior approval list for instructions
HCPCS	S1040	Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)	See prior approval list for instructions

Attachment II
ICD-10-CM Codes

Code Type	Number	Code Description
The following diagnosis codes will be considered as medically necessary when applicable criteria have been met.		
ICD - 10-CM	Q67.3	Plagiocephaly
ICD 10-CM	Q75.0	Craniosynostosis