Clinical Policy: Cranial Remolding Orthosis

Reference Number: TX.CP.MP.523
Last Review Date: 11/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Cranial remolding orthosis is used to treat members diagnosed with craniosynostosis or plagiocephaly/brachycephaly. This policy provides the medical necessity criteria for cranial remolding orthosis for the following products: STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP.

Policy/Criteria

I. It is the policy of Superior HealthPlan that a cranial remolding orthosis for craniosynostosis is **medically necessary** when the following criteria are met:
- A. Member is between 3 months to 18 months of age; *and*
- B. Following cranial vault remodeling surgery for synostosis.

II. It is the policy of Superior HealthPlan that a cranial remolding orthosis for a diagnosis of plagiocephaly/brachycephaly is **medically necessary** when the following criteria are met:
- A. Member is between 3 months to 18 months of age; *and*
- B. Documented failure of conservative therapy for at least 2 months, *and*
  Note: physical therapy, repositioning etc.
- C. **One** of the following sets of measurements or indications:
  1. Asymmetrical appearance confirmed by a right/left discrepancy of greater than **6 mm** in a craniofacial anthropometric measurement, *or*
  2. Brachycephalic or dolichocephalic disproportion in the comparison of length to head width confirmed by a cephalic index of two standard deviations above or below the mean.

Cephalic Index Measurements						
Sex	Age	−2 SD	−1 SD	Mean	+1 SD	+2 SD
Male	16 days – 6 months	63.7	68.7	73.7	78.7	83.7
	6 – 12 months	64.8	71.4	78	84.6	91.2
Female	16 days – 6 months	63.9	68.6	73.3	78	82.7
	6 – 12 months	69.5	74	78.5	83	87.5

Note: SD = Standard Deviation

III. Additional devices may be considered for prior authorization with documentation of *all the following:*

A. The initial device was obtained to treat craniosynostosis.
B. Treatment with the device has been effective.
C. The new device is needed due to growth.
D. Objective documentation indicates potential for additional clinical improvement.

Background

Texas House Bil 426 (89th, 2025-2026) expanded treatment coverage for childhood cranial remolding orthosis for Medicaid and CHIP. The coverage required under this policy will not be less favorable than the coverage required for other orthotics under the medical assistance program**.**

Appendix

Definitions:

- *Brachycephaly* - a cranial deformity characterized by a flattened or shortened appearance of the back of the head, often resulting from external forces or genetic factors. This condition can affect the overall shape and symmetry of the skull, and in some cases, may require medical intervention.
- *Cranial Remolding Orthosis* - a custom-fitted or custom-fabricated medical device that is applied to the head to correct a deformity, improve function, or relieve symptoms of a structural cranial disease.
- *Craniosynostosis* - the premature fusion of one or more cranial sutures, presents a spectrum of challenges ranging from altered skull morphology to potential neurodevelopmental impairment.
- *Plagiocephaly* - also known as deformational plagiocephaly or positional plagiocephaly, is a common and treatable condition that causes a baby's soft skull to become flattened in one area due to continuous pressure on that part of the head.
- *Synostotic Cranial Deformity* - A asymmetrically shaped head may be synostotic or non-synostotic in etiology. Synostosis, defined as premature closure of the sutures of the cranium, may even result in functional deficits secondary to increasing intracranial pressure in an abnormally or asymmetrically shaped cranium. Synostotic deformities are addressed by surgical remodeling of the cranial vault.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	N/A

HCPCS® Codes	Description
S1040	Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created.	11/25	11/25

References

1. The American Academy of Pediatrics (AAP) Clinical Practice guidelines, "Prevention and Management of Positional Skull Deformities in Infant," AAP Committee on Practice and Ambulatory Medicine, Section on Neurological Surgery, *Pediatrics* 2011;128;1236.
2. Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, 2.2.19.3 Cranial Molding Orthosis, October 2025.
3. Texas House Bill 426 (89th Legislature, 2025-2026)
4. American Academy of Orthotists and Prosthetists (AAOP). Orthotic Treatment of Deformational Plagiocephaly, Brachycephaly and Scaphocephaly. Clinical Standards of Practice (CSOP) Consensus Conference on Orthotic Management of Plagiocephaly, 2004
5. Dias MS, Samson T, Rizk EB, Governale LS, Richtsmeier JT; Section on Neurologic Surgery; Section on Plastic and Reconstructive Surgery. Identifying the misshapen head: craniosynostosis and related disorders. *Pediatrics*. 2020;146(3):e2020015511. doi:10.1542/peds.2020-015511
6. Fish D, Littlefield TR, Geil M, Manwaring KH, Klimo P. Revisiting the cephalic index: the origin, purpose, and current applicability—A narrative review. *J Prosthet Orthot.* 2024;36(2):e35-e48. Accessed November 6, 2025. https://journals.lww.com/jpojournal/fulltext/2024/04000/revisiting_the_cephalic_index__the_origin,.10.aspx

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted

standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.