

## Clinical Policy: Cranial Remolding Orthosis

Reference Number: TX.CP.MP.516

Last Review Date: 03/22

[Coding Implications](#)

[Revision Log](#)

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### Description

Cranial molding orthoses are used to treat members diagnosed with synostotic plagiocephaly. This policy provides the medical necessity criteria for cranial remolding orthoses 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 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. A second cranial remolding orthosis is considered **medically necessary** when the following criteria are met:
  - A. Member is within 6 to 18 months of age;
  - B. Treatment with the initial device has been objectively effective;
  - C. The new device is necessary due to member's growth; and
  - D. Objective documentation indicates potential for additional clinical improvement.
- III. It is the policy of Superior HealthPlan that cranial remolding orthosis is **not medically necessary and therefore is not a covered benefit** for the following indications:
  - A. Treatment of deformational plagiocephaly, because the effective use of a cranial molding orthosis for this diagnosis is controversial and has not been reliably documented in the medical literature.
  - B. Treatment of brachycephaly (i.e. a high cephalic index without cranial asymmetry), as it has not been reliably documented.
- IV. Cranial remolding orthosis for congenital or acquired conditions members greater than 18 months old will be reviewed on a case by case basis by the Plan medical director.

### Appendix

#### Definitions:

- Cranial Remolding Orthosis - Cranial remolding orthoses are usually comprised of 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 remolding orthosis may be medically necessary in the treatment of postsurgical synostosis in pediatric patients.

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- **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.
- **Non-Synostotic Plagiocephaly** - Plagiocephaly without synostosis, also called positional or deformational plagiocephaly, can be associated with various environmental factors including, but not limited to, premature birth, restrictive intrauterine environment, birth trauma, torticollis, cervical anomalies, and sleeping position. It is estimated that about two-thirds of cases may correct spontaneously or after regular changes in sleeping position or following physiotherapy aimed at correcting neck muscle imbalance.

### Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. 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	

HCPCS® Codes	Description
S1040	Cranial molding orthosis

### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	01/12	01/12
Change positional plagiocephaly to deformational plagiocephaly. Deleted definition for DME. Revised work process, signatories and references.	07/14	07/14

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Reviews, Revisions, and Approvals	Date	Approval Date
Removed work process and imbedded in attachment section. Added policy to reference list.	02/15	02/15
Removed work process attachment and placed in separate document. Updated Policy Criteria 2 (d). Grammatical changes. Updated References.	07/15	07/15
Grammatical edits. Updated references and signatories. Removed work process for authorization protocol. Removed dx code 756.0.	07/16	07/16
Updated product lines and review date.	07/17	07/17
Updated revision date, references and signatories. Removed “Important Reminder”.	07/18	07/18
Cranial remolding orthosis, synostotic cranial deformity, non-synostotic plagiocephaly descriptions moved to definitions. Grammatical edits. Updated signatories. Under criteria added objective documentation indicates potential for additional clinical improvement. Removed HCPCS code.	01/19	01/19
Updated to new template from TX.UM.10.16 (TX.CP.MP.516 nomenclature implementation). Added HCPCS S1040 code. Under section III. added “and therefore is not a covered benefit”. Updated references.	02/20	02/20
Annual review. Updated references.	03/21	03/21
Annual review. Updated references.	03/22	03/22

### References

1. Collet, Brent R, “Helmet Therapy for Positional Plagiocephaly and Brachycephaly,” *BMJ* 2014;348:g2906, May1, 2014.
2. Mawji, Aliyah, Robinson Vollman, Ardene, Hatfield, Jennifer, McNeil, Deborah A., and Sauvé, Reginald, “The Incidence of Positional Plagiocephaly: A Cohort Study,” The American Academy of Pediatrics (AAP), *Pediatrics*; originally published online July 8, 2013; DOI: 10.1542/peds.2012-3438.
3. Saint Louis, Catherine, “Helmets Do Little to Help Moderate Infant Skull Flattening, Study Finds,” *The New York Times*, May 1, 2014, page A18.
4. 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.
5. Van Wijk PhD, Renske, Van Vlimmeren, Leo, Groothuis-Oudshoorn, Catharina, Van der Ploeg, Catharina, IJzerman, Maartan, and Boere-Boonekamp, Magda, “Helmet therapy in infants with positional skull deformation: randomized controlled trial”, *BMJ* 2014;348:g2741 doi: 10.1136/bmj.g2741, May 1 2014.
6. Texas Medicaid Provider Procedures Manual, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook, 2.2.19.3 Cranial Molding Orthosis, February 2022.

### Important Reminder

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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.

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and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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.

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