

**Policy:** MP125

**Section:** Medical Benefit Policy

**Subject:** Cranial Remodeling Orthotic

### **I. Policy:** Cranial Remodeling Orthotic

### **II. Purpose/Objective:**

To provide a policy of coverage regarding Cranial Remodeling Orthotic

### **III. Responsibility:**

- A. Medical Directors
- B. Medical Management

### **IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

### **V. Additional Definitions**

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

### **Medicaid Business Segment**

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**Plagiocephaly:** an asymmetrically shaped head.

**Non-synostotic plagiocephaly:** also called positional plagiocephaly can be secondary to various environmental factors including, but not limited to, premature birth, restrictive intrauterine environment, birth trauma, and sleeping position.

**DESCRIPTION:**

Cranial remodeling orthotic devices are intended to apply pressure to prominent regions of the cranium in order to improve cranial symmetry in infants with moderate to severe non-synostotic positional plagiocephaly.

**INDICATIONS:**

Cranial remodeling orthotics may be considered medically necessary in infants less than eighteen (18) months of age who:

- Are diagnosed with synostotic plagiocephaly and the orthotic is being used during the post-surgical period; **or**
- are diagnosed with non-synostotic positional plagiocephaly; **and**
  - have not responded to a two-month trial of repositioning **or**;
  - a 2-month trial of physical therapy if appropriate because of clinical condition (e.g. congenital torticollis); **and**
  - are considered unlikely to respond to continued repositioning or physical therapy due to the severity of the deformity (generally 2 standard deviations or more above or below the mean cranial index for age and gender). Note: Cranial Index (CI) is defined as the ratio of the width ÷ length x 100. A CI ranging from 76-90% is considered normocephalic.

**LIMITATIONS:**

Coverage is subject to any conditions or limitations as may be described in the applicable benefit documents.

**EXCLUSIONS:**

There is insufficient evidence to support the efficacy of cranial remodeling orthotic use in children older than 18 months of age and is therefore **NOT COVERED**.

Cranial orthotic devices are not intended for use in infants with head deformities due to uncorrected craniosynostosis or hydrocephalus and is therefore **NOT COVERED**.

**Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis

**CODING ASSOCIATED WITH: Cranial Remodeling Orthotic**

**The coding listed in this document may not represent the comprehensive range of codes that may be associated with this service.**

A8000 Helmet, protective, soft, prefabricated, includes all components and accessories

A8001 Helmet, protective, hard, prefabricated, includes all components and accessories

A8002 Helmet, protective, soft, custom fabricated, includes all components and accessories

A8003 Helmet, protective, hard, custom fabricated, includes all components and accessories

A8004 Soft interface for helmet, replacement only

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)

**LINE OF BUSINESS:**

**Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.**

## REFERENCES:

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This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 5/05

**Revised:** 6/06 (references); 6/07, 7/16 (added indication), 6/19 (added cephalic index criteria per DHS), 6/22 (clarified exclusions)

**Reviewed:** 6/08, 6/09, 7/10, 7/11, 7/12, 7/13, 7/14, 7/15, 6/17, 6/18, 6/20, 6/21, 6/23

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

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