

Plagiocephaly and Craniosynostosis Treatment (for Kansas Only)

Policy Number: CS095KS.02
Effective Date: February 1, 2026

[➔ Instructions for Use](#)

Table of Contents	Page
Application	1
Coverage Rationale	1
Medical Records Documentation Used for Reviews	1
Applicable Codes	1
U.S. Food and Drug Administration	2
References	2
Policy History/Revision Information	2
Instructions for Use	2

- | Related Policies |
|--|
| <ul style="list-style-type: none"> • Cosmetic and Reconstructive Procedures (for Kansas Only) • Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Kansas Only) |

Application

This Medical Policy only applies to the state of Kansas.

Coverage Rationale

For medical necessity clinical coverage criteria for plagiocephaly and craniosynostosis treatment, refer to the [Kansas Medical Assistance Program, Durable Medical Equipment Fee-for-Service Provider Manual](#).

For surgical treatment to repair craniosynostosis (CPT code 21175), refer to the Medical Policy titled [Cosmetic and Reconstructive Procedures \(for Kansas Only\)](#).

For repair or replacement of cranial orthoses, refer to the Medical Policy titled [Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements \(for Kansas Only\)](#).

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the services requested.

The patient's medical record must contain documentation that fully supports the medical necessity for the requested services. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CDT Code	Description
D5924	Cranial prosthesis

CDT® is a registered trademark of the American Dental Association

HCPCS Code	Description
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 orthotic, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Cranial orthoses are classified by the FDA as Class II devices. This classification requires special controls, including prescription use, biocompatibility testing, and labeling (contraindications, warnings, precautions, adverse events, and instructions for physicians and parents). They are intended for medical purposes to apply pressure to prominent regions of an infant's cranium in order to improve cranial symmetry and/or shape in infants from 3 to 18 months of age, with moderate to severe nonsynostotic positional plagiocephaly, including infants with plagiocephalic, brachycephalic, and scaphocephalic-shaped heads. The FDA has approved a large number of cranial orthoses. Additional information under product code MVA is available at: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed November 14, 2025)

References

Kansas Medical Assistance Program Durable Medical Equipment Fee-for-Service Provider Manual. Available at: https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/DME_25204_25201.pdf. Accessed November 14, 2025.

Policy History/Revision Information

Date	Summary of Changes
02/01/2026	<p>Medical Records Documentation Used for Reviews</p> <ul style="list-style-type: none"> • Added language to indicate: <ul style="list-style-type: none"> ○ Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request <p>Supporting Information</p> <ul style="list-style-type: none"> • Updated <i>References</i> section to reflect the most current information • Archived previous policy version CS095KS.01

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its

policies and guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) criteria for substance use disorder (SUD) services, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies that have been approved by the Kansas Department of Health and Environment. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.