Cranial Orthoses for Cranial Deformities and Congenital Muscular Torticollis Clinical Coverage Criteria

Overview

Plagiocephaly is a cranial deformity characterized by asymmetrical flattening of the infant skull and is broadly classified as synostotic or non-synostotic. Synostotic plagiocephaly, also known as craniosynostosis, results from the premature fusion of one or more cranial sutures, restricting normal skull growth and often requiring surgical intervention. Surgical management may include open cranial vault reconstruction or minimally invasive endoscopic procedures, with postoperative cranial orthoses frequently used to guide skull growth and maintain surgical correction. Non-synostotic, or positional, plagiocephaly occurs in the absence of suture fusion and is typically associated with external molding forces, such as preferred sleep positioning, limited mobility, or congenital muscular torticollis. Conservative management is generally considered first-line treatment and may include repositioning strategies, physical therapy, and caregiver education. For infants with persistent moderate-to-severe cranial asymmetry despite appropriate conservative treatment, cranial orthoses may be prescribed to facilitate more symmetric skull growth during periods of rapid cranial development. The use of cranial orthoses is intended to correct cranial shape abnormalities and is generally most effective when initiated during early infancy.

Congenital muscular torticollis (CMT) is a musculoskeletal condition of infancy characterized by unilateral shortening or tightness of the sternocleidomastoid muscle, resulting in head tilt, neck rotation preference, and restricted cervical range of motion. Persistent positioning associated with CMT may lead to cranial asymmetry, including positional plagiocephaly, due to prolonged external pressure on one area of the skull. First-line treatment typically consists of conservative measures such as repositioning, caregiver education, stretching exercises, and physical therapy to improve neck mobility and restore symmetrical movement patterns. When cranial asymmetry persists despite appropriate conservative management, cranial orthoses may be considered to help guide skull growth and improve head shape. Cranial orthoses are used to address the associated cranial deformity rather than the underlying muscular condition and are most effective when initiated during early infancy, when cranial growth is most rapid.

Policy

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Cranial orthoses for cranial deformities (S1040) and custom cranial orthoses for congenital muscular torticollis (L0112) require prior authorization. Prefabricated orthoses for congenital muscular torticollis (L0113) do not require prior authorization.

Fallon Health Clinical Coverage Criteria

Cranial Orthoses for Cranial Deformities

Fallon Health Clinical Coverage Criteria for cranial orthoses for cranial deformities apply to Medicare and Community Care members.

Effective for dates of service on and after September 1, 2026, Fallon Health will use InterQual® Criteria when making medical necessity determinations for cranial orthoses for cranial deformities for Medicare and Community Care members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Orthoses, Cranial Remodeling
  - Cranial Remodeling Orthotic, Pediatric, Rigid, w/Soft Interface Material, Custom Fabricated, w/Fitting, Adjustments (S1040)

Cranial Orthoses for Congenital Muscular Torticollis
Fallon Health Clinical Coverage Criteria for cranial orthoses for congenital muscular torticollis apply to all plan members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Orthoses, Cranial Remodeling
  - Cranial Cervical Orthosis, Congenital Torticollis Type, With or Without Soft Interface Material, Adjustable Range of Motion Joint, Custom Fabricated (L0112)
  - Cranial Cervical Orthosis, Torticollis Type, With or Without Joint, With or Without Soft Interface Material, Prefabricated, Includes Fitting And Adjustment (L0113)

Fallon Health makes InterQual® Criteria available to the public through the transparency tool on our website, effective January 1, 2024.

Medicare Variation

Medicare statutes and regulations do not have coverage criteria for cranial orthoses for cranial deformities and congenital muscular torticollis. Medicare does not have an NCD for cranial orthoses for cranial deformities and congenital muscular torticollis. Noridian Healthcare Solutions, LLC, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) with jurisdiction in the Plan's service area does not have an LCD for cranial orthoses for cranial deformities and congenital muscular torticollis (Medicare Coverage Database search 08/01/2026). When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

MassHealth Variation

MassHealth has Guidelines for Medical Necessity Determination for Cranial Orthoses (Revised Policy Effective: March 23, 2023) (MassHealth website search 08/01/2026). The MassHealth Guidelines include criteria for cranial orthoses for cranial deformities only; the MassHealth Guidelines do not include criteria for cranial orthoses for congenital muscular torticollis.

Coverage criteria for cranial orthoses for cranial deformities (S1040) are fully established by MassHealth.

For cranial orthoses used to treat congenital muscular torticollis (L0112 and L0113), Fallon Health Clinical Coverage Criteria will apply in the absence of an applicable Medicare Local Coverage Determination (LCD). If the provider believes a cranial orthosis for congenital muscular torticollis is medically necessary for the member, even though the request does not meet Fallon Health Clinical Coverage Criteria, the provider must demonstrate medical necessity in accordance with 130 CMR 450.204: *Medical Necessity*, and 130 CMR 442.413.

Prescribing Provider is defined in MassHealth Program Regulations at 130 CMR 442.402 as a physician, doctor of osteopathy (DO), nurse practitioner, physician assistant, or podiatrist who prescribes and writes the prescription for all orthotics and orthotic services.

For all orthotics requiring prior authorization, a Detailed Written Order signed and dated by the member's Prescribing Provider must be completed prior to submission of the prior authorization request to Fallon Health, in accordance with MassHealth regulations at 130 CMR 442.409. Fallon Health reserves the right to request a copy of the Detailed Written Order.

Exclusions

- Cranial orthoses are considered not medically necessary when the medical necessity criteria specified in this policy are not met, including but not limited to cases in which the degree of cranial asymmetry does not meet established treatment thresholds, conservative management has not been appropriately attempted when required, or the requested use is for indications not supported by the available evidence.

Summary of Evidence

N/A

Analysis of Evidence (Rational for Determination)

N/A

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

HCPCS code S1040 is not payable for Fallon Medicare Plus members. The Medicare Physician Fee Schedule Status Indicator = "I" (Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services).

Code	Description	Prior Authorization (PA) Required
L0112	Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated	PA required eff 12/1/2026
L0113	Cranial cervical orthosis, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment	No
S1040	Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)	Yes

References

1. Kaplan SL, Coulter C, Fetters L. Physical Therapy Management of Congenital Muscular Torticollis: An Evidence-Based Clinical Practice Guideline. Pediatric Physical Therapy. 2018;30(4):240-290.
2. American Physical Therapy Association (APTA) Congenital Muscular Torticollis Clinical Practice Guideline Resources. Available at: https://pediatricapta.org/clinical-practice-guidelines/Congenital-Muscular-Torticollis.cfm. Accessed August 1, 2026.
3. Sargent B, Coulter C, Cannoy J, Kaplan SL. Physical Therapy Management of Congenital Muscular Torticollis: A 2024 Evidence-Based Clinical Practice Guideline From the American Physical Therapy Association Academy of Pediatric Physical Therapy. Pediatr Phys Ther. 2024 Oct 1;36(4):370-421.
4. Laughlin J, Luerssen TG, Dias MS; Committee on Practice and Ambulatory Medicine, Section on Neurological Surgery. Prevention and management of positional skull deformities in infants. Pediatrics. 2011 Dec;128(6):1236-41.
5. Congress of Neurological Surgeons. Role of Repositioning in Positional Plagiocephaly Guideline. Available at: https://www.cns.org/guidelines/browse-guidelines-detail/4-role-of-repositioning. Accessed August 1, 2026.
6. Congress of Neurological Surgeons. Guidelines for the Management of Patients with Positional Plagiocephaly. Available at: https://www.cns.org/guidelines/browse-guidelines-detail/5-role-of-cranial-molding-orthosis-helmet-therapy. Accessed August 1, 2026.
7. Tamber MS, Nikas D, Beier A, et al. Guidelines: Congress of Neurological Surgeons Systematic Review and Evidence-Based Guideline on the Role of Cranial Molding Orthosis (Helmet) Therapy for Patients With Positional Plagiocephaly. Neurosurgery. 2016 Nov;79(5):E632-E633.

8. Lam SK, Luerssen TG. AAP News. New guidelines review evidence on PT, helmets for positional plagiocephaly. October 27, 2016. Available at: https://publications.aap.org/aapnews/news/12256/New-guidelines-review-evidence-on-PT-helmets-for. Accessed August 1, 2026.

Policy history

Origination date:	09/01/2026
Review/Approval(s):	Technology Assessment Committee: N/A Utilization Management Committee: 08/18/2026 (policy origination; approved).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.