Medical Necessity Guidelines: Pectus Deformity Repair (Pediatric)

Effective: December 3, 2018

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

<table>
<thead>
<tr>
<th>Applies to:</th>
<th>Yes ☒ No ☐</th>
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<tbody>
<tr>
<td>COMMERCIAL Products</td>
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<tr>
<td>☒ Tufts Health Plan products; Fax: 617.972.9409</td>
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<tr>
<td>☒ Tufts Health Freedom Plan products; Fax: 617.972.9409</td>
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<tr>
<td>• CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</td>
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<tr>
<td>TUFTS HEALTH PUBLIC PLANS Products</td>
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<tr>
<td>☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055</td>
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<tr>
<td>☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055</td>
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<tr>
<td>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
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<tr>
<td>☐ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607</td>
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<td>*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.</td>
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<td>SENIOR Products</td>
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<tr>
<td>• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List</td>
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<tr>
<td>• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List</td>
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</tbody>
</table>

To obtain InterQual® SmartSheets™:

- Tufts Health Plan Commercial Plan products and Tufts Health Freedom Plan products: If you are a registered Tufts Health Plan provider click here to access the Provider website. If you are not a Tufts Health Plan provider please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888.884.2404.

- Tufts Health Public Plans products: InterQual SmartSheet(s) available as part of the prior authorization process.

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Tufts Health Plan requires prior authorization for Pectus Deformity Repair (Pediatric).

In order to obtain prior authorization for procedure(s), the appropriate InterQual SmartSheet(s), listed below, must be completed and sent to the applicable fax number listed above, according to Plan.

- **Pectus Deformity Repair (Pediatric)**

**CODES**

Procedures REQUIRING PRIOR AUTHORIZATION:

Tufts Health Plan will be using InterQual SmartSheet(s) for the following procedure code(s).

**PECTUS DEFORMITY REPAIR (PEDIATRIC)**

The following CPT code(s) require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>21740</td>
<td>Reconstruction repair of pectus excavatum or carinatum; open</td>
</tr>
<tr>
<td>21742</td>
<td>Reconstruction repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thorascopy</td>
</tr>
<tr>
<td>21743</td>
<td>Reconstruction repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thorascopy</td>
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</table>
LIMITATIONS
Tufts Health Plan does not cover the surgical correction of Pectus Carinatum as it is considered to be not medically necessary.

REFERENCES

APPROVAL HISTORY
May 2002: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:
- August 11, 2003: Reviewed and renewed, updated to new format
- October 22, 2004: Reviewed, coverage of breast asymmetry due to Poland’s Syndrome added to the criteria
- October 21, 2005: Requirement for a Welch Index greater than 5 was removed from the criteria
- November 1, 2006: Pectus Carinatum removed from the title of the criteria as it is listed as a limitation of the procedure
- March 5, 2007: Reviewed and renewed, format updated
- April 18, 2008: Reviewed and renewed without changes
- December 2009: Reviewed by Medical Policy, no changes
- December 2010: Admin process changed to RN/LPN
- April 2011: Reviewed at MSPAC, no changes
- July 11, 2012: Criteria for coverage of corrective surgery for Poland’s Syndrome clarified
- October 10, 2013: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC). A completed InterQual® SmartSheet™ for Pectus Excavatum Repair will be required effective October 1, 2013. Poland Syndrome: Surgical Correction removed from Prior Authorization
- December 10, 2014: Reviewed by IMPAC, renewed without changes
- January 1, 2015: Instructions for Tufts Health Plan – Network Health products included in this document
- April 8, 2015: Reviewed by IMPAC, renewed without changes
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- April 13, 2016: Reviewed by IMPAC, renewed without changes
- April 12, 2017: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- March 14, 2018: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- December 3, 2018: 2018.2 InterQual® upgrade for Tufts Health Commercial products including Freedom. Effective December 17, 2018, InterQual® upgrade is effective for Tufts Health Direct and Tufts Health Together. Effective January 14, 2019, InterQual® upgrade for Tufts Health
BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.