Medical Necessity Guidelines: Pectus Excavatum Repair (Pediatric)

Effective: October 10, 2018


Applies to:
☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409
☒ Tufts Health Direct — Health Connector; Fax: 888.415.9055
☒ Tufts Health Together — A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify — OneCare Plan; Fax: 781.393.2607
☒ Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

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, 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) are 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 Excavatum 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 Excavatum Repair (Pediatric)**

**CODES**

**Procedures REQUIRING PRIOR AUTHORIZATION:**
Tufts Health Plan will be using InterQual SmartSheet(s) for the following procedure code(s).

**PECTUS EXCAVATUM REPAIR (PEDIATRIC)**
The following CPT code(s) require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>

**LIMITATIONS**
Tufts Health Plan does not cover the surgical correction of Pectus Carinatum as it is considered to be not medically necessary.

**REFERENCES**
8. Shamberger, R & Welch, K, Surgical repair of pectus excavatum, J Pediatric Surgery. 1988; 23(7),

**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
- April 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

**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.
Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. 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. Applicable state or federal mandates or other requirements will take precedence. For CareLink℠ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines 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.