

## Pectus Deformity Repair (for Indiana Only)

Guideline Number: CS094IN.05

Effective Date: June 1, 2022

 [Instructions for Use](#)

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### Related Policy

- [Cosmetic and Reconstructive Procedures \(for Indiana Only\)](#)

## Application

This Coverage Determination Guideline only applies to the state of Indiana.

## Coverage Rationale

Pectus deformity repair is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Pectus Deformity Repair (Pediatric).

Click [here](#) to view the InterQual® criteria.

### Documentation Requirements

Medical notes documenting the following, when applicable:

- Diagnosis
- History of the medical condition(s) requiring treatment or surgical intervention
- Documentation of functional limitation/impairment
- Results of all recent imaging studies and applicable diagnostics, including results of:
  - CT scan including Haller Index calculation
  - Pulmonary function test
  - Echocardiogram including ejection fraction
  - Stress test including cardiopulmonary function values
- Physician treatment plan

## 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.

CPT Code	Description
21740	Reconstructive repair of pectus excavatum or carinatum; open

CPT Code	Description
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy

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Diagnosis Code	Description
Q67.6	Pectus excavatum
Q67.7	Pectus carinatum

## Guideline History/Revision Information

Date	Summary of Changes
06/01/2022	<p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"> <li>Removed reference to specific InterQual® release date; refer to the most current InterQual® criteria</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Archived previous policy version CS094IN.04</li> </ul>

## Instructions for Use

This Coverage Determination Guideline 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 guideline, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines 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.