

Lung Volume Reduction Surgery (for North Carolina Only)

Policy Number: CSNCT0703.03
Effective Date: May 1, 2022

[Instructions for Use](#)

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Related Policies
None

Application

This Medical Policy only applies to the state of North Carolina.

Coverage Rationale

Lung volume reduction surgery is proven and medically necessary for treating bilateral emphysema. For medical necessity clinical coverage criteria, refer to the InterQual® 2022, Apr. 2022 Release, CP: Procedures, Lung Volume Reduction Surgery (LVRS).

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

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
32491	Removal of lung, other than pneumonectomy; with resection-plectomy of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed
32672	Thoracoscopy, surgical; with resection-plectomy for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed

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Policy History/Revision Information

Date	Summary of Changes
05/01/2022	<p data-bbox="337 218 594 247">Coverage Rationale</p> <ul data-bbox="337 254 1430 317" style="list-style-type: none"><li data-bbox="337 254 1430 317">● Replaced reference to “InterQual® 2021, July 2021 Release” with “InterQual® 2022, Apr. 2022 Release” <p data-bbox="337 323 639 352">Supporting Information</p> <ul data-bbox="337 359 935 388" style="list-style-type: none"><li data-bbox="337 359 935 388">● Archived previous policy version CSNCT0703.02

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, 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 Medical Policy 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 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.