PECTUS DEFORMITY REPAIR

Policy Number: SURGERY 065.16 T2

Effective Date: July 1, 2019

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Conditions of Coverage

Applicable Lines of Business/Products
This policy applies to Oxford Commercial plan membership.

Benefit Type
General benefits package

Referral Required
No

Authorization Required
Yes¹

Precertification with Medical Director Review Required
Yes¹

Applicable Site(s) of Service
Inpatient¹, Outpatient¹

Special Considerations
¹Precertification with review by a Medical Director or their designee is required.

Coverage Rationale

Indications for Coverage
Surgical repair of Pectus Excavatum is considered reconstructive and medically necessary when the following criteria has been met:
• Imaging studies confirm Haller Index greater than 3.25; and
• The Functional Impairment is defined in physician office notes, and
  o For restrictive lung capacity the total lung capacity is documented in the physician office notes as <80% of the predicted value; or
  o There is cardiac compromise as demonstrated by decreased cardiac output on the echocardiogram; or
  o There is objective evidence of exercise intolerance as documented by cardiopulmonary exercise testing that is below the predicted values.

Surgical repair of Pectus Carinatum may be considered reconstructive and medically necessary. Requests for coverage of repair of Pectus Carinatum will be reviewed by an Oxford Medical Director on a case-by-case basis.

Coverage Limitations and Exclusions
Oxford excludes Cosmetic Procedures from coverage including but not limited to the following:
• Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.
• Procedures that do not meet the reconstructive criteria in the Indications for Coverage section.

**DOCUMENTATION REQUIREMENTS**

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

**Required Clinical Information**

**Pectus Excavatum**

Medical notes documenting all of the following:

- Results of imaging studies (CT scan confirming Haller Index greater than 3.25)
- Documentation of functional limitation/impairment
- Results of:
  - Pulmonary function test (confirming restrictive lung capacity) the total lung capacity is documented as <80% of the predicted value; or
  - One of the following:
    - An echocardiogram (Ejection Fraction) confirming by decreased cardiac output
    - Stress test demonstrating cardiopulmonary function that is below the predicted values
- Physician treatment plan

**Pectus Carinatum**

Medical notes documenting all of the following:

- Documentation of functional limitation/impairment
- Physician treatment plan

**DEFINITIONS**

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

**Congenital Anomaly**: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

**Cosmetic Surgery**: Defined by the American Society of Plastic Surgeons, "is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."

**Functional or Physical or Physiological Impairment**: A Physical or Functional or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

**Haller Index**: The Haller Index, or pectus severity index, is the most commonly used scale for determining the severity of chest wall deformities. Computerized tomography (CT) is used to determine the index, which is obtained by dividing the inner width of the chest at its widest point by the distance between the posterior surface of the sternum and the anterior surface of the spine. This measurement uses the deepest level of the inner sternal depression to the anterior aspect of the vertebral body. A normal chest has a Haller Index of about 2.5.

**Pectus Carinatum**: A protrusion of the chest over the sternum. It is extremely uncommon that Pectus Carinatum will cause a functional or physiological deficit. Pectus Carinatum is not a Congenital Anomaly; it is a developmental condition of the cartilage that generally occurs during an adolescents growth spurt.

**Pectus Excavatum**: Posterior depression of the sternum and adjacent costal.

**Sickness**: Physical illness, disease or Pregnancy. The term Sickness does not include mental illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

**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 the member specific benefit plan.
document 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 may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>21740</td>
<td>Reconstructive repair of pectus excavatum or carinatum; open</td>
</tr>
<tr>
<td>21742</td>
<td>Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy</td>
</tr>
<tr>
<td>21743</td>
<td>Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy</td>
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<thead>
<tr>
<th>ICD-10 Diagnosis Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Q67.6</td>
<td>Pectus excavatum</td>
</tr>
<tr>
<td>Q67.7</td>
<td>Pectus carinatum</td>
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REFERENCES
The foregoing Oxford policy has been adapted from an existing UnitedHealthcare Coverage Determination Guideline (CDG) that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee.


POLICY HISTORY/REVISION INFORMATION

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<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>07/01/2019</td>
<td>Template Update</td>
</tr>
<tr>
<td></td>
<td>• Added Documentation Requirements section</td>
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<tr>
<td></td>
<td>Coverage Rationale</td>
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<tr>
<td></td>
<td>• Routine review; no change to guidelines</td>
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<td>Supporting Information</td>
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<td>• Archived previous policy version SURGERY 065.15 T2</td>
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INSTRUCTIONS FOR USE
This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical 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.