Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP050

Section: Medical Benefit Policy

Subject: Surgical Correction of Chest Wall Deformities

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Surgical Correction of Chest Wall Deformities

II. Purpose/Objective:

To provide a policy of coverage regarding Surgical Correction of Chest Wall Deformities

III. Responsibility:

A. Medical Directors

B. Medical Management Department

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community;
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

Haller CT index: Gives an objective measurement for comparing the severity between different patients. It is derived from dividing the transverse diameter of the chest by the anterior-posterior diameter.

INDICATIONS:
Surgical repair of Pectus Excavatum and Pectus Carinatum is considered medically necessary if the insured individual meets **ALL** of the following criteria:

1. Well-documented evidence of severe functional impairment arising from the sternal deformity. Complications include but may not be limited to:
    - Cardiopulmonary impairment documented by respiratory and cardiac function tests;
    - Frequent lower respiratory tract infections;
    - Exercise limitations;
    - Atypical chest pain; **AND**
2. An EKG, stress test, echocardiogram, stress echo or cardiac catheterization documented to define the relationship between the cardiopulmonary impairment and the sternal deformity. **AND**
3. A CT scan of the chest that indicates one of the following:
    a Haller CT index* greater than 3.25; **or**

    For members with significant discrepancies of anterior-posterior to medial-lateral dimensions of the chest wall, a Correction Index** of 28% or higher

*Daunt SW, Cohen JH, Miller SF. Age-related normal ranges for the Haller index in children. Pediatric radiology 2004;34(4):326-330.

** St. Peter SD, Juang D,GareyCL, et al. A novel measure for pectus excavatum: the correction index. J Pediatr Surg 2011;46:2270–3.

LIMITATIONS:
Anatomic studies such as chest x-ray, chest CT scan or anteroposterior diameter without evidence of compromise of physiologic function will not be considered primary considerations for surgical correction.

EXCLUSIONS:
Surgical intervention to correct the sternal deformity in the absence of significant medically documented functional impairment and/or cardiopulmonary compromise is considered cosmetic/ not medically necessary and therefore **NOT COVERED.**

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Coding Associated With: Surgical Correction of Chest Wall Deformities
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

21740 Reconstructive repair of pectus excavatum or carinatum
21742 Reconstructive repair of pectus excavatum or carinatum, minimally invasive approach, without thoracoscopy
21743 Reconstructive repair of pectus excavatum or carinatum, minimally invasive approach, with thoracoscopy

LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually**.**

Devised: 9/99

Revised: 12/01, 12/02 (add medical necessity definition); 10/03 change title,add pectus carinatum
09/05 (defined Haller CT and Extended Criteria); 10/09 (criteria); 5/16 (Removed PA); 10/16 (cited reference for Haller Index)

Reviewed: 10/04, 10/06, 10/07, 10/08, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 9/17, 9/18; 9/19, 9/20, 9/21, 9/22