

Pectus Surgery and Devices, Surgical 05

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<u>Effective Date</u>	5/1/2026
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<u>Coverage Policy</u>	Surgical 05
<u>Version</u>	8

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Description & Definitions:

Congenital defects known as **pectus excavatum (PE)**, or funnel chest, and **pectus carinatum**, known as pigeon breast, are anomalies of the anterior chest wall characterized by a deep depression of the sternum. Surgical procedures and devices exist to correct the anomaly.

Other common names: Nuss Procedure, Pectus support bar, Pectus Excavatum Strut, MedXpert Pectus Excavatum System (P.E.S.), Minimally Invasive Repair of Pectus Excavatum (MIRPE), Vacuum bell therapy (VBT), Dynamic compression bracing

Criteria:

Pectus Surgery and Devices are considered medical necessary for the repair of pectus excavatum or pectus carinatum for **1 or more** of the following:

- **Repair of pectus excavatum by any technique (surgery or Vacuum Bell Therapy (VBT))** is considered medically necessary for **ALL** of the following:
 - **Imaging by 1 or more of the following:**
 - Computed tomography
 - Echocardiogram
 - Magnetic resonance imaging (MRI) scan
 - Ultrasound of the chest
 - Haller index (pectus severity index) of greater than 2.0
 - Symptomatic with **1 or more** of the following:
 - Breathing difficulties
 - Cardiac issues related to chest deformity (compression)
 - Chest pain directly related to the chest wall deformity
 - Exercise limitations or intolerance
- **Repair of pectus carinatum by any technique (surgery or orthotic or dynamic compression bracing)** is considered medically necessary with **ALL** of the following:
 - **Imaging by 1 or more of the following:**
 - Computed tomography
 - Echocardiogram

- Magnetic resonance imaging (MRI) scan
 - Ultrasound of the chest
- Haller index (pectus severity index) less than 2.0
- Symptomatic with **1 or more** of the following:
 - Breathing difficulties
 - Cardiac issues related to chest deformity (compression)
 - Chest pain directly related to the chest wall deformity
 - Exercise limitations or intolerance
- Dynamic compression bracing for members individual's who require less than 7.5 psi compression to achieve correction and is considered cosmetic (L1320)
- Surgical repair for chest wall deformity associated with individual's diagnosis of Poland syndrome

Pectus Surgery and Devices are considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Repair of pectus excavatum or pectus carinatum by any technique to improve appearance, in the absence of functional impairment is considered cosmetic
- Silicone prosthetic inserts (L9900)
- Sternal magnet (i.e. Magnetic Mini Mover Procedure (3MP)) (21740)
- Suit or vest therapy including, but not limited to the Benik vest, Stabilizing Pressure Input Orthosis (SPIO), Adeli Suit, Penguin Suit, Polish Suit, Therapy Suit, Therasuit, and TheraTogs (L9900)

Document History:

Revised Dates:

- 2025: January – Implementation date of May 1, 2026. Change and update criteria and deleting some exceptions
- 2025: February
- 2020: January
- 2016: February
- 2015: October
- 2013: February, June

Reviewed Dates:

- 2023: January
- 2022: January
- 2021: January
- 2018: August
- 2017: November
- 2015: February
- 2014: February
- 2012: February
- 2011: February

Origination Date: February 2010

Coding:

Medically necessary with criteria:

Coding	Description
21740	Reconstructive repair of pectus excavatum or carinatum; open
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

L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated

Considered Not Medically Necessary:

Coding	Description
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Policy Approach and Special Notes: *

- Coverage
 - Requests for brace checks of cosmetically applied pectus carinatum braces will be denied in accordance with group benefit exclusions for cosmetic procedures.
 - See the appropriate benefit document for specific coverage determination. Individual specific benefits take precedence over medical policy.
- Application to products
 - Policy is applicable to Sentara Health Plan Commercial products.
- Authorization requirements
 - Pre-certification by the Plan is required.
- Special Notes:
 - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
 - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Pectus, excavatum, sternum, brace, orthotic, carinatum, Haller index, pectus severity index, SHP Pectus Surgery and Devices, SHP Surgical 05, cardiopulmonary compromise, cardiac compression, Suit therapy, vest therapy, Benik vest, Stabilizing Pressure Input Orthosis, SPIO, Adeli Suit, Penguin Suit, Polish Suit, Therapy Suit, Therasuit, TheraTogs, Vacuum bell, sternal magnet, silicone prosthetic inserts, Nuss Procedure, Pectus support bar, Pectus Excavatum Strut