

**Affected Programs:** BadgerCare Plus, Medicaid

**To:** Nurse Practitioners, Physician Assistants, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

## New Prior Authorization Criteria for Pectus Excavatum/Carinatum Surgery

This *ForwardHealth Update* introduces new prior authorization (PA) approval criteria for pectus excavatum/carinatum surgery effective for PA requests received on and after October 15, 2011.

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### Prior Authorization Policy

Congenital chest wall deformities may result in functional limitations such as activity intolerance related to cardiac or respiratory impairment. Patients often report symptoms that include mild to moderate exercise limitations, respiratory infections, and asthmatic conditions. In many cases, the deformity does not lead to functional impairment, and treatment is considered to be solely cosmetic in nature. Pectus carinatum has not been found to cause functional impairment, and surgical repair is considered to be cosmetic.

Prior authorization requests for pectus excavatum/carinatum surgery may be approved under DHS 107.06(2)(c), Wis. Admin. Code, which states PA is required for the following:

Surgical or medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed

to significantly interfere with a recipient's personal or social adjustment or employability, an example of which is cosmetic surgery.

### Prior Authorization Approval Criteria for Pectus Excavatum

Any *one* of the following criteria must be met for PA requests for repair of severe pectus excavatum when the pectus index (i.e., Haller index<sup>1</sup>) is greater than 3.25:

- Pulmonary function studies demonstrate at least moderately severe restrictive airway disease.
- Echocardiograph demonstrates findings consistent with external compression.
- Abnormal cardiovascular or ventilator limitation is evident during cardiopulmonary exercise testing.
- Documentation of progression of the deformity with associated physical symptoms other than isolated concerns of body image.

The approval criteria for PA requests for pectus excavatum surgery are also included in the Attachment of this *Update*.

### Covered Services

Providers may be reimbursed for pectus excavatum/carinatum surgery using any of the following *Current Procedural Terminology* procedure codes:

- 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).

Allowable *International Classification of Disease, Ninth Revision, Clinical Modification* diagnosis codes include the following:

- 754.81 (Pectus excavatum).
- 754.82 (Pectus carinatum).

All pectus excavatum/carinatum procedures require PA. A pectus excavatum/carinatum procedure that does not meet the PA approval criteria is considered a noncovered service. Any charges related to the noncovered pectus excavatum/carinatum procedure will not be reimbursed.

### **How to Submit Prior Authorization Requests**

All of the following must be included as part of a PA request for pectus excavatum/carinatum surgery:

- A completed Prior Authorization Request Form (PA/RF), F-11018 (10/08).
- A completed Prior Authorization/Physician Attachment (PA/PA), F-11016 (10/08).
- Documentation supporting the criteria in the Prior Authorization Approval Criteria for Pectus Excavatum section of this *Update*.

Providers may submit PA requests via the ForwardHealth Portal, including the capability to upload electronically completed PA attachments and additional required documentation. Providers may refer to the Portal User Guide available on the ForwardHealth Portal for instructions on submitting PA attachments.

Providers may submit paper PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth  
 Prior Authorization  
 Ste 88  
 6406 Bridge Rd  
 Madison WI 53784-0088

For complete PA information, refer to the Physician service area in the Online Handbook.

### **Information Regarding Managed Care Organizations**

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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<sup>1</sup>The degree of deformity can be determined by dividing the inner width of the chest at the widest point by the distance between the posterior surface of the sternum and the anterior surface of the spine. Computerized Tomography scans are better able to define the ratio of anterior-posterior (AP) borders to transverse diameters, also referred to as the pectus index or Haller Index. Diameters are taken at the deepest level of the sternal depression. Computerized Tomography scan ratios that reveal transverse to AP diameter of greater than 3.25 are considered significant for pectus excavatum. A normal chest has an index of 2.5.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).

P-1250

This *Update* was issued on October 10, 2011, and information contained in this *Update* was incorporated into the Online Handbook on October 20, 2011.

# **ATTACHMENT**

## **Prior Authorization Approval Criteria for Pectus Excavatum**

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