Quartz

Pectus Carinatum: Orthotic Devices and Surgical Correction

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Policy

The Medical Management Department reviews referral requests for authorization of Pectus Carinatum Orthotic Devices

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

A. Documentation Required

In order to facilitate the authorization process referral requests must include the following:

1. Clinical documentation of pectus carinatum, **AND**
2. Clinical documentation of the reason for bracing including patient symptoms and any testing related to determining the cause of the symptoms to be related to pectus carinatum, **AND**
3. Order from a pediatric surgeon; **AND**
4. The orthotist developing the dynamic compression bracing device must be certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics.

B. Criteria for Medical Necessity for Bracing

Treatment of **Pectus Carinatum** with an **orthotic compression bracing device** or **dynamic compression bracing device** is considered medically necessary for patients who meet **ALL** of the following criteria:

1. Patient is at least age 5 years and not older than age 19 years at the start of bracing therapy; **AND**
2. Patient has at least **ONE** of the following:
    a. Symptomatic respiratory insufficiency or restricted air exchange manifested by:
        i. Shortness of breath with routine activity or exercise; **AND**
        ii. Documented restrictive lung disease on pulmonary function testing with FEV1/FVC ratio <80% of predicted for patient; **OR**
        iii. Sternal or rib cage pain due to pectus carinatum requiring the use of medication at least 3 days per week (e.g., analgesics, sleeping medication, etc.) to control symptoms; **AND**
3. Patient symptoms are thought to be directly related to the pectus carinatum abnormality and that bracing will result in a lessening or resolution of the patient's symptoms; **AND**
4. The patient's pressure of initial correction (PIC) is < 10 PSI.

Note:

- Patient shall receive one dynamic compression bracing device per lifetime for pectus carinatum.
- Patient and caregiver(s) must receive education and training from the Orthotist about the bracing protocol and how to care for and maintain the brace.

C. Criteria for Medical Necessity for Surgical Treatment of Pectus Carinatum is determined using InterQual® criteria.

D. Indications Considered Experimental or Investigational for Bracing Treatment:

1. Patient has significant asymmetry of the pectus carinatum deformity by a concomitant pectus excavatum-type deformity.

E. Indications Considered not Medically Necessary for Bracing Treatment

1. Patients in whom bracing is performed solely to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints is considered cosmetic.

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