Clinical Review Criteria Related to Rhinoplasty

I. Criteria for Approval

A. Rhinoplasty is a cosmetic procedure and only considered medically necessary in the following:

1. To correct a nasal deformity secondary to a congenital cleft lip/palate or severe congenital raniofacial deformity when associated with severe functional impairment.

2. Chronic airway obstruction from vestibular stenosis (collapsed internal/external valves) due to trauma, disease or congenital defect when the following are met: nasal airway obstruction is causing significant symptoms; and obstruction symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids or immunotherapy and; photographs demonstrate an external deformity, and there is significant obstruction of one or both nares documented by nasal endoscopy, computed tomography scan or other appropriate imaging modality; and airway obstruction will not respond to septoplasty and turbinectomy alone.

3. A fracture greater than nine weeks post trauma.

4. A fracture diagnosed by CT scan or facial X-ray.

5. Other causes have been eliminated as the cause of the nasal obstruction (e.g., sinusitis, allergic rhinitis, nasal polyposis, adenoid hypertrophy, nasopharyngeal masses).

6. Benign or malignant neoplasms

II. Required Documentation

A. Clinical notes documenting

1. Relevant history

2. Congenital defect or disease
3. A physical exam confirming moderate-to-severe vestibular obstruction

4. Documentation of a 3month trial of conservative management such as nasal steroids or immunotherapy

5. Duration and degree of symptoms related to nasal obstruction

6. CT Scan and facial X-ray report

7. Frontal, lateral and nares angled photographs demonstrating nasal deformity

8. Endoscopic evaluation confirming nasal valve compromise or dynamic collapse of the external nasal valve or upper lateral cartilage

III. What is Not Covered

A. Primary treatment for obstructive sleep apnea

B. Cosmetic solely for the purpose of changing appearance

IV. CPT/ ICD-10/ HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

ICD 10 Codes

J34.2 Deviated nasal septum (causing continuous nasal airway obstruction resulting in nasal breathing difficulty not responding to appropriate medical therapy)

J32-J32.9 Chronic sinusitis (due to deviated septum not relieved by appropriate medical antibiotic therapy)

M95.0 Acquired deformity of nose that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (not covered for nasal valve collapse)

Q30.1 Other anomalies of nose

Q37-Q37.9 Cleft palate/lip
Q67.0  Certain congenital musculoskeletal deformities of skull, face, jaw  
S02.0  Late effect fracture of skull and face bones

**CPT Codes**

- **30400**  Rhinoplasty, primary: lateral and alar cartilages and/or elevation of nasal tip  
- **30410**  Rhinoplasty, primary: complete external parts including bony pyramid, lateral and alar cartilages and/or elevation of nasal tip  
- **30420**  Rhinoplasty, primary, including major septal repair  
- **30430**  Rhinoplasty, secondary, minor revision (small amount of nasal tip work)  
- **30435**  Rhinoplasty, secondary, intermediate revision (bony with osteotomies)  
- **30450**  Rhinoplasty, secondary, major revision (nasal tip work with osteotomies)  
- **30460**  Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate including columellar lengthening: tip only  
- **30462**  Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate including columellar lengthening: tip, septum, osteotomies  
- **30465**  Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)

**V. References**

NCQA Standard, UM 2, Clinical Criteria for Utilization Management Decisions, Element A  

(Last Accessed 4/6/16, 2/9/17)

CMS.gov Local Coverage Determination: Cosmetic and Reconstructive Surgery (L34698)  
[https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34698&ver=15&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Massachusetts&KeyWord=cosmetic+surgery&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAABAAAAAAA%3d%3d&](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34698&ver=15&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Massachusetts&KeyWord=cosmetic+surgery&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAABAAAAAAA%3d%3d&)  
(Last Accessed 4/6/16, 2/9/17)

**VI. Summary of Changes**

06/29/2017
• Added new Disclaimer
• Section II Required Documentation #7 - Changed wording
• References – Updated last accessed dates
• ICD 9 codes removed

VII. Review Dates

HNE Review Dates: 09/10/13, 9/9/14, 9/8/15, 6/14/16, 5/9/17
MHI Review Dates: 01/1/14, 10/23/14, 10/07/15, 6/30/16, 06/29/2017
Medical Guideline Disclaimer
The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical review criteria based upon a review of currently available clinical information (including, without limitation clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by Minuteman. If there is a discrepancy between this policy and a member’s benefit program, the benefit program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management, administrative and other services to its members.