UnitedHealthcare®

COVERAGE DETERMINATION GUIDELINE

RHINOPLASTY AND REPAIR OF VESTIBULAR STENOSIS

Guideline Number: CDG.019.02
Effective Date: July 1, 2014

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Related Policies:

- Plagiocephaly and Craniosynostosis Treatment
- Cosmetic and Reconstructive Procedures
- Orthognathic (Jaw) Surgery

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting certain standard UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs), and Medicaid State Contracts) may differ greatly from the standard benefit plans upon which this guideline is based. In the event of a conflict, the enrollee's specific benefit document supersedes these guidelines. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and medical policies may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its coverage determination guidelines and medical policies as necessary. This Coverage Determination Guideline does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COVERAGE RATIONALE

Plan Document Language

Before using this guideline, please check enrollee's specific plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group:
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the enrollee's specific plan document to determine benefit coverage.

Indications for Coverage

Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to enrollee's plan specific documents.

RHINOPLASTY FOR NASAL VESTIBULAR STENOSIS OR ALAR COLLAPSE:
Repair of nasal vestibular stenosis or alar collapse is considered reconstructive and medically necessary when **all** of the following criteria are present:

A. Prolonged, persistent obstructed nasal breathing due to internal and/or external nasal valve compromise (see definition below), and

B. Internal and/or external nasal valve compromise causes an anatomic mechanical nasal airway obstruction and is a primary contributing factor for obstructed nasal breathing. (eg. large cutaneous defect, malignancy or trauma), and

C. Other causes have been eliminated as the primary cause of nasal obstruction (eg. sinusitis, allergic rhinitis, vasomotor rhinitis, nasal polyposis, adenoid hypertrophy, nasopharyngeal masses)

RHINOPLASTY FOR CONGENITAL ANOMALIES:
The following are considered reconstructive and medically necessary when the following criteria are present:

Rhinoplasty for repair of Congenital Anomalies, when a functional impairment exists, may be considered reconstructive. Rhinoplasty is considered reconstructive when performed in conjunction with a covered correction of congenital craniofacial anomalies including, but not limited to, correction of cleft lip, or cleft palate.

Medical Necessity Plans: Please use the criteria above where applicable.

California Only: This is the mandated language for Reconstructive Procedures - Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or create a normal appearance, to the extent possible.

Coverage Limitations and Exclusions

Cosmetic Procedures are excluded from coverage, including but not limited to:

A. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

B. Rhinoplasty, unless rhinoplasty criteria above are met

C. Any procedure that does not meet the reconstructive criteria above

D. Rhinoplasty procedures performed to improve appearance (check enrollee's plan specific document)

DEFINITIONS

When applicable, please refer to the enrollee-specific plan document for definitions.

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth. (2011 Generic COC)

Congenital Anomaly (California Only): A physical developmental defect that is present at birth

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by UHC (2011 Generic COC)

Cosmetic Procedures (California Only): Procedures or services are performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance

Functional/Physical Impairment: A physical/functional or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Reconstructive Procedures: Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure. (2011 Generic COC)

Reconstructive Procedures (California Only): Reconstructive procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible.

APPLICABLE CODES

The Current Procedural Terminology (CPT®) codes and Healthcare Common Procedure Coding System (HCPCS) codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the enrollee specific benefit document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other policies and coverage determination guidelines may apply. This list of codes may not be all inclusive.

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IMPORTANT: All nasal surgical claims may be subject to coding review.

Limited to specific procedure codes?	☒ YES ☐ NO

CPT® Procedure Code	Description
RHINOPLASTY REPAIR	
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 work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and 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
SURGICAL REPAIR OF VESTIBULAR STENOSIS	
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
MISCELLANEOUS CODES	
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)

Limited to specific diagnosis codes?	☐ YES ☒ NO
Limited to place of service (POS)?	☐ YES ☒ NO
Limited to specific provider type?	☐ YES ☒ NO
Limited to specific revenue codes?	☐ YES ☒ NO

REFERENCES

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GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
07/01/2014	• Changed policy title; previously titled *Rhinoplasty, Septoplasty and Repair of Vestibular Stenosis* • Reformatted table of contents; removed applicable products grid • Revised coverage rationale/indications for coverage: o Removed documentation requirements o Removed content/guidelines related to septoplasty procedures: ▪ Septoplasty for nasal obstruction ▪ Septoplasty for septal deformity that limits access for endoscopic sinus surgery ▪ Septoplasty for nasal/septal fracture o Updated coverage guidelines for *Rhinoplasty for Nasal Vestibular Stenosis or Alar Collapse*; added language to indicate repair of nasal vestibular stenosis or alar collapse is considered reconstructive **and medically necessary** when the applicable criteria is met (as outlined)

Date	Action/Description
	o Updated coverage guidelines for *Rhinoplasty for Congenital Anomalies*; added language to indicate the noted indications are considered reconstructive **and medically necessary** when the applicable criteria is met (as outlined) o Removed benefit considerations language specific to ASO plans • Revised definitions: o Removed definition of: ▪ Chronic sinusitis ▪ High quality photograph ▪ Nasal endoscopy ▪ Nasal valve ▪ Nasal vestibular stenosis ▪ Recurrent acute sinusitis ▪ Rhinitis medicamentosa (RM) ▪ Rhinoplasty ▪ Septoplasty ▪ Sickness ▪ Sinus surgery (endoscopy) o Removed definitions/language specific to the 2001 and 2007 Certificates of Coverage (COCs) • Revised list of applicable CPT codes: o Removed language indicating CPT codes 21310 - 21337 are typically associated with the treatment of acute nasal fractures o Added language indicating all nasal surgical claims may be subject to coding review. o Removed list of applicable codes for septoplasty (30520) o Removed 30120 from list of applicable miscellaneous codes (refer to the CDG titled *Cosmetic and Reconstructive Procedures*) • Archived previous policy version CDG.019.01