Medical Policy:  
Rhinoplasty (Commercial)

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>LAST REVIEW DATE</th>
<th>APPROVED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>MG.MM.SU.08h</td>
<td>03/13/2020</td>
<td>MPC (Medical Policy Committee)</td>
</tr>
</tbody>
</table>

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including 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). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular 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 ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member’s benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

Definitions

| Rhinoplasty | Rhinoplasty is a surgical procedure of the nose to correct external nasal deformity while maintaining, restoring or improving nasal function. |

Related Medical Guidelines

Cosmetic Surgery Procedures  
Septoplasty

Guideline

Members are eligible for rhinoplasty when either of the following criteria is met and high-quality photographs are provided in four views (right and left lateral, anterior, and base or worm’s view):¹
1. Performed in conjunction with a septrhaphy for nasal airway obstruction when the nasal deformity contributes to the airway obstruction and septrhaphy criteria are met.

2. Performed as part of reconstruction for severe deformity when documented obstructive breathing symptoms secondary to any of the following are present:
   - Excision of a nasal abscess.
   - Excision of a malignant mass.
   - Osteomyelitis.
   - Cleft lip and/or palate repair.
   - Nasal trauma or injury within a 18 month period that resulted in significant deviation of the nasal pyramid or a creation of a significant dorsal hump. Documentation of care by physician at time of the trauma and x-ray evidence of fracture of the nasal bonces or facial bones must be submitted upon request.
   - Nasal dermoid
   - Saddle nose deformity’ from a large septal perforation either from surgery, trauma, or disease (Granulomatosis with Polyangiitis).
   - Vestibular stenosis for prolonged nasal obstruction which is moderate to severe, separate from obstruction caused by deviated septum or turbinate hypertrophy, and causing problems such as breathing difficulty, bleeding, or sinusitis.

1 The Plan must receive substantiating documentation that demonstrates the presence of nasal obstruction as a prerequisite to a medical necessity evaluation by a Medical Director.

Limitations/Exclusions

Rhinoplasty is not covered when any of the following are applicable:

1. Performed solely to change appearance in the absence of any signs or symptoms of functional abnormalities or nasal defects, as this would be considered cosmetic.

2. For treatment of polyps not causing severe deformity.

Applicable Coding

To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

References

Specialty-matched clinical peer review.
Revision history

<table>
<thead>
<tr>
<th>DATE</th>
<th>REVISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/13/2020</td>
<td>Added nasal dermoid, saddle nose deformity and vestibular stenosis as</td>
</tr>
<tr>
<td></td>
<td>covered indications</td>
</tr>
<tr>
<td></td>
<td>Added Related Medical Guidelines</td>
</tr>
<tr>
<td>09/13/2019</td>
<td>Reformatted and reorganized policy, transferred content to new template</td>
</tr>
</tbody>
</table>