

Document ID#: 1036641
Subject: Rhinoplasty
Effective Date: May 1, 2011

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	LPN

Please Note: Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Overview

Rhinoplasty is defined as plastic surgery of the nose (Taber's, 1993).

Coverage Guidelines

Tufts Health Plan will approve coverage for rhinoplasty when the Member meets **either** of the following:

1. The Member is under 19 years of age, and the planned surgery is secondary to cleft lip and/or cleft palate repair.

OR

2. a) The Member has a nasal bone displacement which is causing nasal airway obstruction and the obstruction cannot be relieved by septoplasty alone **and**;
b) The Member's obstructive symptoms have failed to respond to oral and/or intranasal decongestants.

Limitations

- Tufts Health Plan will not cover rhinoplasty for cosmetic reasons, such as improving the appearance of a Member's nose.
- In the event that the requested procedure is septorhinoplasty, and only septoplasty is required to correct the functional impairment, Tufts Health Plan may authorize the septoplasty procedure as a partial approval.

Codes

The following CPT codes require prior authorization:

Code	Description
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)

References

Thomas, Clayton, ed. Taber's Cyclopedic Medical Dictionary. Philadelphia: F.A. Davis Co, 1993: 1722.

Approval History

Reviewed by the Clinical Coverage Criteria Committee on June 23, 2003.

Subsequent Endorsement Date(s) and Changes Made:

- June 23, 2003: New criteria in 2003.
- June 28, 2004: Limitation of partial approval for septoplasty added.
- October 21, 2005: Reviewed and renewed, no changes made.
- November 1, 2006: Reviewed and renewed, no changes made.
- November 13, 2007: Reviewed and renewed, no changes made.
- February 27, 2008: Reviewed and renewed, no changes made.
- March 16, 2009: Reviewed and renewed, no changes made.
- April 2010: Reviewed at MSPAC, no changes.
- December 2010: Reviewed by Medical Affairs-Medical Policy. Recent trauma criteria removed. New criteria added at 2a and 2b.
- February 2011: CPT codes 30460 and 30462 removed from MNG as they are now incorporated into iHT edit.
- April 2011: Reviewed by MSPAC. No changes.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts

Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.