

## Rhinoplasty Criteria

<b>Iowa Medicaid Program:</b>	Prior Authorization; Claims Pre-pay	<b>Effective Date:</b>	7/1/2008
<b>Revision Number:</b>	5	<b>Last Review Date:</b>	4/21/2017
<b>Reviewed By:</b>	Medicaid Clinical Advisory Committee	<b>Next Review Date:</b>	4/2018
<b>Approved By:</b>	Medicaid Medical Director	<b>Approved Date:</b>	5/5/2017

### Criteria:

**ALL** of the following must be met:

1. The member must have a relevant history of any symptomatic trauma, surgical sequelae, congenital defect, or disease process causing a symptomatic functional impairment.
2. The procedure is performed for correction or repair of **ANY** of the following:
  - a. Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing a functional impairment
  - b. Chronic, nonseptal, nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves).
  - c. Secondary to symptomatic trauma, disease, congenital defect with nasal airway obstruction unresponsive to a recent trial of conservative medical management lasting at least six weeks that has either not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with septoplasty/turbinectomy alone.
3. Preoperative photographs of any symptomatic external deformity showing anterior, base, left and right lateral view must be supplied and must be consistent with the need for rhinoplasty.

Procedures requested for cosmetic purposes will not be covered.

### CPT Codes:

30460 – 30462 Cleft Lip/Palate  
 30400 – 30420 Primary  
 30430 – 30450 Secondary

### References Used:

Medicare LCD 32763, <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDid=32762&Contrid=330&ver=45&ContrVer=1&Date=&DocID=L32763&bc=iAAAAAgAAAAAA%3d&> Accessed 1/2/15.

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

**Change History:**

<b>Change Date:</b>	<b>Changed By:</b>	<b>Description of Change:</b>	<b>New Version Number:</b>
10/19/12	CAC	Criteria - remove #1 and re-number #2 and #3 to #1 and #2. Add to #1 after disease process "causing a symptomatic functional impairment"	1
7/19/13	CAC	Criterion #1 corrected spelling of sequelae.	2
4/18/14	Medical Director	Formatting changes. Added "procedures for cosmetic purposes will not be covered".	3
4/17/15	CAC	Added Criterion #2 and references.	4
6/8/15	Policy Staff	Removed "primarily" from procedures for cosmetic purposes will not be covered.	5

**C. David Smith, MD**