Medical Coverage Policy

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Otoplasty and External Ear Reconstruction

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health

benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses otoplasty and external ear reconstruction. Otoplasty, a procedure to correct protruding ears, is performed to improve the appearance of ears. External ear reconstruction is a surgical procedure that attempts to reconstruct the external ear to normal anatomical shape.

Coverage Policy

Coverage for otoplasty and/or external ear reconstruction is dependent on benefit plan language and may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit. In addition, this service may be governed by state mandates. Please refer to the applicable benefit plan documents and schedule of copayments to determine benefit availability and the terms, conditions, and limitations of coverage.

External ear reconstruction for the treatment of an external ear deformity or the absence of an external ear is considered medically necessary when ANY of the following criteria is met:

- hearing is expected to improve
- reconstruction is necessary to allow the use of a conventional air conduction hearing aid, cochlear implant, or prescription eyewear, when documented with frontal, lateral or oblique, and posterior photographs with the device being worn which demonstrates that the external ear deformity is preventing the functional ability to use the device for the correction of a current hearing or visual deficit

Non-surgical external ear molding is considered medically necessary for a congenital external ear malformation in an individual with a functional impairment of hearing.

Each of the following are considered cosmetic in nature and not medically necessary when performed solely to improve physical appearance:

- external ear reconstruction
- ear molding

Otoplasty (CPT® code 69300) is considered cosmetic in nature and not medically necessary for ANY indication, including ALL of the following:

- prominent/protruding ears
- lop ears
- cupped ears
- constricted ears
- performed to increase the individual's comfort level when wearing protective or assistive equipment (e.g., helmet, headphones, mask, non-prescriptive worn sunglasses)
- performed to treat psychological symptomatology or psychosocial complaints
- when performed for the sole purpose of improving appearance

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

External Ear Reconstruction

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
69399†	Unlisted procedure, external ear

†**Note: Considered Medically Necessary when used to report ear molding and the above criteria in the policy statement is met.**

Considered Medically Necessary when submitted with a medically necessary procedure:

CPT®* Codes	Description
20910	Cartilage graft; costochondral
20912	Cartilage graft; nasal septum
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)

Otoplasty

Considered Cosmetic/Not Medically Necessary

CPT®* Codes	Description
69300	Otoplasty, protruding ear, with or without size reduction

General Background

Abnormalities of the external ear, such as microtia, anotia, malformation, deformity, and partial or complete loss of the auricle (the visible outer part of the ear) may occur as a congenital condition or be acquired through trauma, surgery, or disease. The external ear plays a critical role in auditory function by collecting and directing sound waves into the external auditory canal. When the external ear is absent or malformed, this pathway is disrupted, often resulting in conductive hearing loss due to impaired sound transmission to the middle and inner ear. Beyond its auditory function, the external ear provides essential anatomical support for external devices, including hearing aids, cochlear implant processors, and eyeglasses, ensuring proper fit and retention.

Recognition of these structural and functional roles is important for planning reconstructive interventions (Malick, et al., 2023).

Management of external ear malformations ranges from observation and prosthetic placement to surgical correction. Minor abnormalities may not require intervention, while severe cases might need surgery to address functional deficits. Non-surgical options, such as ear molding, are often effective when started soon after birth because neonatal auricular cartilage remains pliable due to maternal estrogen (Andrews, et al., 2024).

External ear reconstruction performed solely to alter physical appearance, without associated hearing loss or functional impairment, is classified as a cosmetic procedure. Such interventions aim to improve aesthetic outcomes rather than improve function.

Otoplasty is defined as a surgical procedure designed to give the auricle a more natural and anatomic appearance. It is the most common example of a purely cosmetic ear surgery, typically performed to correct prominent ears or other minor deformities.

Congenital Abnormalities - Prominent/Protruding Ears: Prominent/protruding ears are a congenital abnormality in which the ears tend to project excessively from the skull without causing a functional deficit (Liaw, et al., 2017). "Cup ear" or "loop ear" involves a loss of height of the ear and may be referred to as a prominent ear deformity. This condition may occur as a result of an inadequately formed antihelix (i.e., the outer frame of the auricle), an overdeveloped or excessively deep concha (i.e., hollow portion of the outer ear), or a combination of these conditions (American Society of Plastic Surgeons [ASPS], 2005; Reaffirmed June 2015). Ear prominence is typically defined as a protrusion of the helix 2 cm or more from the postauricular scalp. Otoplasty performed to correct prominent ears involves recreating an antihelical fold and possibly in setting or resecting the concha to decrease the prominence. The primary goal of surgical correction for prominent/protruding ears is improvement of physical appearance, which is considered cosmetic.

Congenital Abnormalities - Microtia: Microtia (small external ear) is a congenital anomaly characterized by incomplete development of the auricle, with severity traditionally classified into grades I, II, and III. Grade I represents a mildly underdeveloped auricle, while grade III involves near absence of auricular structures. Anotia, which is the complete absence of the external ear, is often considered an extreme form of grade III microtia. The auricle serves important functions, including aiding in sound localization and providing structural support for eyeglasses (Wu 2010). When malformations of the external ear can interfere with the ability to wear hearing aids or glasses, which is of particular importance given the high incidence of craniofacial or ocular abnormalities associated with microtia, reconstruction is necessary (Cuccolo, et al., 2019).

Trauma/Neoplasm: Trauma to the ear may result from burn injuries, human or animal bites, falls or motor vehicle accidents. The unavoidable exposure to sun of the helical rim of the ear contributes to the development of skin neoplasm and removal with precise margin control is recommended. Despite efforts to preserve healthy tissue in the presence of tissue injury or neoplasm, reconstruction is often necessary to improve physical appearance and function. Reconstruction to improve physical appearance in the absence of improving function is considered cosmetic.

Cochlear Implant: Sensorineural hearing loss may occur as a result of congenital defects, disease or trauma. When the hearing loss becomes profound and a hearing aid is ineffective, a cochlear implant may maximize hearing ability for patients.

Cochlear implants have two integral components:

- The internal component consists of a receiver-stimulator connected to an infracochlear electrode array made up of electrode rings that are integrated into a silicone carrier. The stimulator is implanted in the skull near the cochlea and is connected to the electrode array via a lead wire.
- The external component consists of a microphone worn on the external ear, a speech processor worn at ear-level or on the body, and a transmitter worn behind the ear.

The external component consists of a speech processor that contains a microphone and processor. The speech processor is integral in translating acoustic sounds into electrical signals that can then be presented to intracochlear electrodes for stimulation of the residual spiral ganglion cells. There are three types of processors, each worn in a different way.

- Body worn processors: Initial devices utilized body worn processors but were ultimately superseded by behind-the-ear processors.
- Behind-the-ear processors (BTEs): BTE processors are currently the standard of choice for cochlear implant recipients. These are worn behind the ear and require the presence of an outer ear to provide stability.
- Off-the-ear processors (OTEs): Recent advances in processor technology have introduced OTE devices as an alternative to BTE. OTE processors are held in place through the use of an implanted magnet (Ayas, et al., 2025).

A systematic comparison conducted outside of North America reported that BTE and OTE speech processors perform comparably in various environments. There was no clearly identifiable superior device. No reported studies are found from North America comparing BTE to OTE. BTE processors remain the standard of choice (Ayas, et al., 2025).

Cochlear microphone placement may be difficult in some cases and external ear reconstruction may be required to facilitate use of the device (Lin, et al., 2005). If the ear is absent or too small to hold the behind-the-ear (BTE) processor, it must be clipped to the clothing. The microphone, which is activated to pick up speech and environmental sounds, then has to be turned off to avoid the excessive noise from the clothing rubbing against them. If external ear reconstruction is conducted so the ear can support the processor, the microphone can then be used as intended. Careful planning and extensive counselling should be undertaken prior to cochlear implantation surgery (Neo, et al., 2023). Reconstruction performed to facilitate the effective use of functional devices, including cochlear implant speech processors, is considered medically necessary.

Treatment Options - Non-Surgical Treatment

Non-surgical treatment options for the treatment of congenital external ear malformation include splinting and molding. Ideally, treatment is initiated within the first two weeks of life and may continue until the infant is three months old. The ear molding process involves the application of a rigid cradle that surrounds the patient’s auricle and adheres firmly to the skin. Retention taping is required, which can lead to mal-adhesion and early loosening of the material. Other non-surgical treatment options are available, such as a prosthetic auricle or bone anchored hearing aid device, depending on the nature and severity of the functional impairment (Feijen, et al., 2020; Schultz, et al., 2017).

Treatment Options - Surgical Treatment

Porous polyethylene (PPE) implant auricular reconstruction and autologous rib cartilage reconstruction are two examples of surgical reconstruction methods of the external ear.

The PPE implant auricular reconstruction process, which involves the use of a 3D implant, typically involves a one-stage approach, unless there is any necessity for tissue expansion before auricle

reconstruction, to achieve both esthetic and functional outcomes. Suitable candidates include children as young as 3 years old. The adoption of PPE implants as the preferred treatment option is limited due to limited evidence-based literature reporting long term performance but offers a promising surgical reconstruction option (Hussein, et al., 2025).

Autologous cartilage graft reconstruction, which involves a multi-step approach including rib cartilage harvest, is considered the gold standard due to long standing clinical track record, surgeon familiarity, and robust literature support. Candidates typically require older children, who are around 10 years old (Hussein, et al., 2025).

The overall goal of surgical intervention is to reconstruct a functional ear. Any goal related solely to creating a more conventionally appearing ear without an expected improvement in the functional status of the individual is considered cosmetic. It is important to recognize that each person's ears often show some asymmetry with various components of the ear and in their relative proximity to the scalp and is not necessarily considered a malformation. Unless the asymmetry adversely affects a person's ability to use behind the ear devices (such as hearing aids, cochlear implant processors, or prescription eyewear) effectively, treatment is considered cosmetic.

Complications associated with otoplasty may include tissue necrosis, hematoma, bleeding, infection, or hypertrophic scarring (Feijen, 2020). Similar complications may be associated with surgical external ear reconstructive procedures, with the addition of pneumothorax if a rib graft is used for autologous cartilage graft reconstruction.

Professional Societies/Organizations
American Academy of Pediatrics (AAP): Guidelines and/or position statements from the AAP do not comment on the performance of otoplasty for treatment of external ear deformities.

American Society of Plastic Surgeons (ASPS): According to the ASPS, otoplasty is considered a reconstructive surgery when it is performed to approximate a normal appearance, even if it does not improve function. Otoplasty may be performed in children or adults, although the procedure is more common in children (ASPS, 2005; Reaffirmed June 2015).

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

It is estimated that one in every 3800 babies is born with anotia/microtia, with males 2.5 times more frequently affected than females. Also, there is a higher prevalence of microtia in Hispanic/Latinix (3.13 per 10,000) and Native America/Native Alaskan (4.67 per 10,000) populations compared to an overall prevalence of 1.69 per 10,000 live births (Zopf, et al., 2021).

Most causes of anotia/microtia are unknown although some cases are found to be caused by a genetic mutation or taking Accutane during pregnancy. Women diagnosed with diabetes prior to

pregnancy and a maternal diet lower in carbohydrates and folic acid have a higher risk for having a baby born with anotia or microtia compared to their counterparts (CDC, 2024).

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Revision Details

Type of Revision	Summary of Changes	Date
Annual Review	External ear reconstruction med nec statement: • Add photo documentation requirement to conventional air conduction hearing aid. • Expand photo documentation flexibility with choice of lateral or 'oblique'. • Add cochlear implant use to med nec reasons for external ear reconstruction when criteria is met. Otoplasty cosmetic / not med nec statement: • Added additional indication examples. Add 'non prescriptive sunglasses' to list of examples of protective/assistive devices. No change to intent.	7/15/2026
Annual Review	No clinical policy statement changes.	4/15/2025
Annual Review	• Revised the policy statement for photographs under the external ear reconstruction section. • Removed the policy statement for 'functional need for eyewear use' under the non-surgical external ear molding section. • Added a policy statement for 'an individual's comfort level' in the not medically necessary section for otoplasty.	4/15/2024