Rhinoplasty and Septoplasty
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Rhinoplasty and Septoplasty		
MNG #: 119	☒ **CCA Senior Care Options (HMO D-SNP) (MA)** ☒ **CCA One Care (Medicare-Medicaid) (MA)**	**Prior Authorization Needed?** ☒ **Yes (always required)** ☐ **Yes (only in certain situations. See this MNG for details)** ☐ **No**
Benefit Type: ☒ **Medicare** ☒ **Medicaid**	**Approval Date:** 03/07/2023;	**Effective Date:** 1/1/25
Last Revised Date: 11/14/24; 1/1/25	**Next Annual Review Date:** 03/07/2024; 11/14/25	**Retire Date:**

OVERVIEW:

Nasal surgeries are procedures that are performed on the external or internal structures of the nose, septum, or turbinate. Nasal surgeries include but are not limited to rhinoplasties, septoplasties, and vestibular stenosis repairs. These procedures may involve the rearrangement or excision of the supporting bony and cartilaginous structures and overlying skin of the nose. Specifically, reconstructive rhinoplasty is a surgical procedure to correct a nasal deformity, to repair damaged nasal structures, and/or to replace lost tissue. Reconstructive septoplasty is the surgical procedure to correct the nasal septal deformity or deviation by altering, splinting, or removing the obstructive tissue. Nasal deformities or damage may be acquired from disease and trauma or arise from congenital anomalies. The nasal surgeries are intended to treat these physiological conditions and address the functional impairments, such as nasal obstruction, so that it allows for optimal nasal airflow. The goal of reconstructive rhinoplasty and septoplasty is to maintain or improve the physiological function of the nose. Any cosmetic improvement in the overall nasal shape and aesthetics is incidental.

DEFINITIONS:

Rhinoplasty is a procedure that changes the shape or appearance of the nose while improving or preserving the nasal airway. The primary purpose for Rhinoplasty can be functional, aesthetic, or both and may include other procedures on the paranasal sinuses, septum, or turbinates.

Septoplasty is a procedure used to correct deformities of the nasal septum which can often cause issues with airflow and difficulty breathing.

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DECISION GUIDELINES:
Commonwealth Care Alliance (CCA) does not cover cosmetic rhinoplasty and/or septoplasty performed solely to enhance appearance.

Clinical Coverage Criteria:

1. Commonwealth Care Alliance may cover **reconstructive rhinoplasty** for the correction and repair of **any** of the following conditions listed in criteria a-d:
    a. Nasal deformity that is secondary to congenital cleft lip and/or palate **and/or** for the removal of a nasal dermoid; and
    i. Photographic evidence of the anatomical abnormality is submitted; **OR**
    b. Severe deformity related to an underlying inflammatory disease (e.g., pleomorphic granulomatosis, granulomatosis with polyangiitis), abscess, osteomyelitis that is causing difficulty breathing, **or** following the removal of nasal malignancy that has caused difficulty breathing and severe deformity; **OR**
    c. Chronic non-septal nasal airway obstruction from vestibular stenosis due to congenital defect, trauma, or disease, and **all** the following criteria are met:
        i. There is persistent and prolonged obstructed nasal breathing; and
        ii. The physical examination confirms moderate to severe vestibular obstruction; and
        iii. The photographs demonstrate an external nasal deformity; and
        iv. The CT scan, nasal endoscopy, or other appropriate imaging modality has demonstrated/documented the presence of significant obstruction in one or both nares; and
        v. Nasal airway obstruction will not or has not responded to turbinectomy and septoplasty alone; and
        vi. Nasal airway obstruction is causing significant symptoms (e.g., difficulty breathing, chronic rhinosinusitis); and
        vii. Nasal airway obstruction symptoms persist despite conservative management for at least four (4) weeks or more; and
            a) Conservative management includes nasal steroids and/**or** immunotherapy; and
        viii. Nasal airway obstruction/functional impairment is expected to be resolved by rhinoplasty; **OR**
    d. Nasal airway obstruction when rhinoplasty is performed as a component of medically necessary septoplasty and there is documentation of gross nasal obstruction on the same side as the septal deviation;

AND

e. Documentation must be submitted for consideration of coverage of **conditions listed in c. and d.** and must include **all** of the following:
    i. The duration and degree of symptoms related to nasal obstruction such as chronic rhinosinusitis, mouth breathing, etc.; and
    ii. The response to conservative management of symptoms; and

iii. Results of nasal endoscopy, CT, or other appropriate imaging modality documenting the degree of nasal obstruction; and

iv. If there is an external nasal deformity, pre-operative photographs showing the standard 4way view or worm's eye view; and

v. Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infectiona with saddle deformity, or congenital deformity).

2. Commonwealth Care Alliance may cover **reconstructive intranasal septoplasty** for the correction and repair of **<u>any</u>** of the following conditions:
    a. Nasal septum trauma resulting in significant functional deformity that was not present before; or
    b. Need for reconstruction after the removal of a tumor, nasal polyp(s), or surgical removal of part of the ethmoid bone; or
    c. Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g., ethmoidectomy); or
    d. Recurrent sinusitis when **<u>all</u>** the following criteria are met:
        i. Documentation of a minimum of three (3) episodes of sinusitis over a 12-month period; and
        ii. The condition is thought to be due to a deviated septum; and
        iii. The condition has not been relieved by appropriate medical and antibiotic therapy; or
    e. Recurrent epistaxis when all of the following criteria are met:
        i. Documentation of a minimum of four (4) episodes of epistaxis over a 12-month period; and
        ii. The condition is thought to be related to an underlying septal deformity; or
    f. Septal deviation when **<u>all</u>** the following criteria are met:
        i. The member has tried four (4) or more weeks of appropriate medical therapy; and
        ii. The condition continues to cause continuous nasal airway obstruction resulting in difficulty breathing; or
    g. When reconstructive septoplasty is performed in association with cleft lip or palate repair; or
    h. Obstructive sleep apnea when **<u>all</u>** the following criteria are met:
        i. The member is having difficulty tolerating continuous positive airway pressure (CPAP) due to significant nasal obstruction; and
        ii. The member's condition is not responding to conservative management; and
        iii. Septoplasty is being performed to enhance CPAP or bilevel positive airway pressure (BiPAP) effectiveness.

3. Commonwealth Care Alliance may cover **extracorporeal septoplasty** for initial correction of an extremely deviated nasal septum that cannot be adequately corrected with an intranasal approach **and** criteria 2 for reconstructive septoplasty is met.

LIMITATIONS/EXCLUSIONS:

1. Commonwealth Care Alliance will limit the following:

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a. If a non-covered cosmetic surgery is performed in the same operative period as a covered surgical procedure, Commonwealth Care Alliance will only provide reimbursement for the covered surgical procedure after receiving prior authorization only; and
b. Upon individual case review by a Medical Director, Commonwealth Care Alliance may cover exceptions to the cosmetic surgery exclusion. This may include, but not limited to:
    i. Surgery in connection with the treatment of severe burns; or
    ii. Severe repair of the face following a serious automobile accident; or
    iii. Surgery for therapeutic purposes which coincidentally serves some cosmetic purpose.

2. Commonwealth Care Alliance will not cover **any** of the following:
    a. Septoplasty for all other indications not listed in the clinical coverage criteria above due to the lack of authoritative evidence to establish its clinical efficacy at this time.
        i. This includes but is not limited to allergic rhinitis
    b. Extracorporeal septoplasty for the revision of deviated septum is considered experimental and investigational for SCO and ICO members, except as stated above (criterion 3)
    c. Rhinoplasty for all other indications not listed in the clinical coverage criteria above due to the lack of authoritative evidence to establish its clinical efficacy at this time
        i. This includes but is not limited to repair of nasal valve collapse, chronic sinusitis
    d. The use of absorbable nasal implant (e.g., Spirox latera absorbable nasal implant) for rhinoplasty
    e. The use of septal swell bodies for the treatment of chronic rhinitis
    f. The use of nasal pyriform aperture reduction for the treatment of nasal obstruction
    g. The use of concentrated growth factor extracted from blood plasma for the repair of nasal septal mucosal defect following rhinoplasty
    h. Rhinoplasty or septoplasty solely for the purpose of changing appearance or improving self-image in the absence of any signs or symptoms of functional abnormalities.

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

CPT/HCPCS CODE	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)

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30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip o
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity [supporting literature (full text preferred) should be attached to the request], or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

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REVISION LOG:

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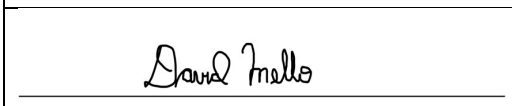
REVISION DATE	DESCRIPTION
1/1/25	CCA products updated. Medicare Advantage Clinical Coverage Criteria removed.
11/14/24	Template update. Definitions and overview section updated. Formatting updated.
12/31/23	Utilization Management Committee approval

APPROVALS:

David Mello	Senior Medical Director Utilization Review and Medical Policy
CCA Clinical Lead	**Title**
	11/14/24
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CCA CMO or Designee	**Title**
	11/14/24
Signature	**Date**