STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Septoplasty/Rhinoplasty
SRG-017

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	7/1/2008
Revision Number:	5	**Last Rev Date:**	4/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	4/18/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	6/4/2018

Descriptive Narrative

Septoplasty is a common procedure performed for the primary indication of nasal airway obstruction. Physical examination with anterior rhinoscopy and nasal endoscopy (NE) is considered the gold standard for detecting and rating septal deviation. Computed tomography (CT) can also be used to evaluate the nasal septum. Preoperative CT scan can be used for further examination of the nasal anatomy and identification of sinonasal pathology. The main indication for CT scan by otolaryngologists is to provide documentation to the insurer of nasal obstruction. However, CT scan has been shown to underestimate the findings of NE for deviations of the internal nasal valve. CT may be indicated when NE is limited by obstruction or in the setting of chronic rhinosinusitis.

Criteria

Septoplasty

The presence of at least **ONE** of the following must be well-documented:

1. Septal deviation causing nasal airway obstruction resulting in prolonged or chronic nasal breathing difficulty, recurrent nasal infections, sleep apnea, or mouth breathing that has proved unresponsive to a recent trial of conservative and medical management, including smoking cessation, if applicable (e.g., topical/nasal corticosteroids, antihistamines) lasting at least 6 weeks; **OR**
2. Recurrent sinusitis secondary to a deviated septum that does not resolve after appropriate medical and antibiotic therapy and **EITHER** of the following indications are present:
   a. Recurrent acute rhinosinusitis: 4 or more acute episodes per year; **OR**
   b. Chronic rhinosinusitis: duration more than 12 weeks; **OR**
3. Recurrent or uncontrollable epistaxis related to a septal deformity; **OR**
4. Asymptomatic septal deformity that prevents access to other transnasal areas when such access is required to perform medically necessary procedures (e.g., ethmoidectomy); **OR**
5. Performed in association with cleft lip or cleft palate repair; **OR**

6. Obstructed nasal breathing due to septal deformity or deviation that has proved unresponsive to medical management and is interfering with the effective use of medically necessary continuous positive airway pressure for the treatment of an obstructive sleep disorder; **OR**
7. Septoplasty may be approved to facilitate removal of a tumor or with resection of nasal polyps; **OR**
8. Septal spur headache.

Septoplasty may also be approved when done in association with cleft palate repair. Documentation must include the following:

1. Documentation must show the clinical history of the degree and duration of symptoms related to nasal obstruction or relevant functional impairment and failed previous attempts at conventional treatment; **AND**
2. Documentation must show any relevant history of symptomatic trauma or surgical sequelae, congenital defect or disease process or note the absence of any of these; **AND**
3. X-ray, CT scan, or NE results.

Rhinoplasty

Rhinoplasty performed solely for cosmetic purposes to improve or change the appearance of the nose is not a covered benefit of Iowa Medicaid. It can be approved for coverage to repair acquired defects due to trauma, congenital defects, surgical sequelae, or disease processes resulting in symptomatic functional impairment when **ALL** the following are met:

1. Nasal deformity secondary to a cleft lip/palate or other congenital deformity resulting in nasal obstruction or other functional impairment; **AND**
2. Chronic, nonseptal nasal obstruction due to vestibular stenosis, (i.e., collapsed internal valves); **AND**
3. Secondary to symptomatic trauma, disease, or congenital defects with nasal airway obstruction which have failed to respond to at least 6 weeks of medical management and have failed to respond to septoplasty/tubinectomy or would not be expected to resolve with septoplasty/tubinectomy.

Preoperative photographs of any symptomatic external deformity showing anterior, base, left and right lateral view must be supplied prior to approval. The photographs should document the need for the rhinoplasty along with other ancillary studies such as AR, NE, or CT scan.

Coding

The following list(s) of codes are provided 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, nor does the exclusion of a code imply that its association to the CPT code is inappropriate.

CPT	Description - Septoplasty
30520	Septoplasty.
30140	Submucous resection.

CPT	Description - Rhinoplasty
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).
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only.
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Centers for Medicare & Medicaid Services, Medicare LCD 32763, http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=32763&ContrId=330&ver=45&ContrVer=1&Date=&DocID=L32763&bc=iAAAAAgAAAAAAA%3d%3d&. Accessed 1/2/2015.

ENT Today, "What are the Indications for the use of CT before septoplasty?", Wotman, M., Kacker, A., June 20, 2017.

Septoplasty- MedlinePlus Medical Encyclopedia, reviewed by editors 4/5/18, US National Library of Medicine, Bethesda, MD.

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.

Criteria Change History

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
Signature			

Change Date	Changed By	Description of Change	Version
4/19/2024	CAC	Annual review.	5
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
4/21/2023	CAC	Annual review.	4
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
4/15/2022	CAC	Annual review.	3
Signature William (Bill) Jagiello, DO			
Change Date	**Changed By**	**Description of Change**	**Version**
4/16/2021	CAC	Annual review. Minor formatting changes.	2
Signature William (Bill) Jagiello, DO			

Criteria Change History (continued)

Change Date	Changed By	Description of Change	Version
4/20/2018	CAC	Combined criteria for Septoplasty and Rhinoplasty	1
Signature C. David Smith, MD