Ear, Nose, and Throat Procedures

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➲ Instructions for Use

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Coverage Rationale

Balloon Sinus Ostial Dilation (Also Known as Balloon Dilation Sinuplasty)

Medicare does not have a National Coverage Determination (NCD) for balloon sinus ostial dilation. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Sinus Surgeries and Interventions.

Eustachian Tube Dilation

Medicare does not have an NCD for eustachian tube dilation. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Functional Endoscopic Sinus Surgery (FESS)

Medicare does not have an NCD for FESS. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Sinus Surgeries and Interventions.

Intranasal Repair

Medicare does not have an NCD for intranasal repair. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Cosmetic and Reconstructive Procedures.

Lithotripsy for Salivary Stones

Medicare does not have an NCD for lithotripsy for salivary stones. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Lithotripsy for Salivary Stones.

Posterior Nasal Nerve Ablation Using Radiofrequency or Cryoablation (e.g., Clarifix)

Medicare does not have an NCD for posterior nasal nerve ablation. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Rhinoplasty and Other Nasal Procedures.

Rhinophototherapy

Medicare does not have an NCD for rhinophototherapy. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Rhinophyma Excision

Medicare does not have a NCD for rhinophyma excision. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Rhinoplasty and Other Nasal Procedures.

Rhinoplasty

Medicare does not have an NCD for rhinoplasty. LCDs/LCAs exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Rhinoplasty.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the coverage rationale below.

- Rhinoplasty is considered reasonable and necessary when there is photographic documentation (**all** of the following: frontal, lateral, and worm's eye view) of the individual's condition, and the procedure is performed for correction or repair of any of the following:
  - Secondary to trauma, disease, or congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with septoplasty/turbinectomy alone
  - Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing a functional impairment
  - Chronic, non-septal, nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves)
- Rhinoplasty/nasal surgery is not reasonable and necessary when performed for either of the following:
  - Solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities
  - As a primary treatment for an obstructive sleep disorder

Septoplasty

Medicare does not have an NCD for septoplasty. LCDs/LCAs exist and compliance with these policies is required where applicable. Refer to the LCDs for cosmetic and reconstructive surgery. For specific LCDs/LCAs, refer to the table for Septoplasty.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the InterQual® CP: Procedures, Septoplasty.

Click here to view the InterQual® criteria.

Vestibular Stenosis Repair

Medicare does not have an NCD for vestibular stenosis repair. LCDs/LCAs exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Vestibular Stenosis Repair.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Rhinoplasty and Other Nasal Procedures.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. 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. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Balloon Sinus Ostial Dilation (Also Known as Balloon Dilation Sinuplasty)	
31295	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); maxillary sinus ostium, transnasal or via canine fossa
31296	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); frontal sinus ostium
31297	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); sphenoid sinus ostium
31298	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); frontal and sphenoid sinus ostia
31299	Unlisted procedure, accessory sinuses
Eustachian Tube Dilation	
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (i.e., balloon dilation); unilateral
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (i.e., balloon dilation); bilateral
69799	Unlisted procedure, middle ear
Functional Endoscopic Sinus Surgery (FESS)	
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
Intranasal Repair	
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
Lithotripsy for Salivary Stones	
42699	Unlisted procedure, salivary glands or ducts
Posterior Nasal Nerve Ablation Using Radiofrequency or Cryoablation (e.g., Clarifix)	
30999	Unlisted procedure, nose
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve
Rhinophototherapy	
30999	Unlisted procedure, nose
Rhinophyma Excision	
30120	Excision or surgical planing of skin of nose for rhinophyma [Refer to the UnitedHealthcare Commercial Medical Policy titled Rhinoplasty and Other Nasal Procedures]
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

CPT Code	Description
Rhinoplasty	
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
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)
Septoplasty	
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Vestibular Stenosis Repair	
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Rhinoplasty				
N/A	L39506 Cosmetic and Reconstructive Surgery	A59299 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	CGS
	L38914 Cosmetic and Reconstructive Surgery	A58573 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	First Coast
	L35163 Plastic Surgery	A57221 Billing and Coding: Plastic Surgery	Part A and B MAC	Noridian
	L37020 Plastic Surgery	A57222 Billing and Coding: Plastic Surgery		
	L35090 Cosmetic and Reconstructive Surgery	A56587 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	Novitas
	L33428 Cosmetic and Reconstructive Surgery	A56658 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	Palmetto
	L39051 Cosmetic and Reconstructive Surgery	A58774 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	WPS*
Septoplasty				
N/A	L39506 Cosmetic and Reconstructive Surgery	A59299 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	CGS
	L38914 Cosmetic and Reconstructive Surgery	A58573 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	First Coast

NCD	LCD	LCA	Contractor Type	Contractor Name
Septoplasty				
N/A	L35090 Cosmetic and Reconstructive Surgery	A56587 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	Novitas
	L33428 Cosmetic and Reconstructive Surgery	A56658 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	Palmetto
	L39051 Cosmetic and Reconstructive Surgery	A58774 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	WPS*
Vestibular Stenosis Repair				
N/A	L38914 Cosmetic and Reconstructive Surgery	A58573 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	First Coast
	L35090 Cosmetic and Reconstructive Surgery	A56587 Billing and Coding: Cosmetic and Reconstructive Surgery	Part A and B MAC	Novitas

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DE, LA, MD, MS, NJ, NM, OK, PA, TX, DC
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
*__Note__: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 – applies only to WPS Legacy Mutual of Omaha MAC A Providers	

Clinical Evidence

Rhinoplasty

A meta-analysis by Zhao et al. (2022) was performed to evaluate the effects of functional rhinoplasty (FRP) on nasal obstruction in patients with nasal valve problems. A total of 57 cohorts from 43 studies involving 2024 patients were included in the current meta-analysis. Level of Evidence III. The Nasal Obstruction Symptom Evaluation (NOSE) scores indicated significant improvement in nasal obstruction at the 1-month, 3-month, 6-month, 12-month, and the last follow-up with respect to the preoperative baseline. The Visual Analogue Scale (VAS) scores indicated a similar trend at the 1-month, 3-month, 6-month, and last follow-up. Nasal obstruction was demonstrated as relieved through rhino-manometry but not through peak nasal inspiratory flow (PNIF). The authors concluded that FRP may have a positive effect on nasal obstruction caused by nasal valve problems. The findings of this study need to be validated by broader, well-designed studies.

Martin et al. (2022) completed a prospective randomized controlled trial (RCT) to evaluate the subjective and objective outcome of septoplasty (SPL) and septorhinoplasty (SRP) on patient satisfaction. Patients with functional indication for SPL (n = 19) or SRP (n = 54) were included and randomized for additional turbinoplasty. Preoperative clinical symptoms were collected with SNOT-20 GAV (Sinu-nasal outcome test-20 - German adapted version) and NOSE© (nasal obstruction symptom evaluation) questionnaires. The final evaluation of treatment success was performed 9 months after surgery with SNOT-20 GAV, NOSE© and a self-established feedback questionnaire. Nasal breathing and obstruction were objectively measured with rhinomanometry and acoustic rhinometry [minimum cross-sectional area 2 (MCA2)]. Minimum cross-sectional area 2 was statistically improved compared to the pre-treatment value in SPL (p = 0.0004) and SRP

(p = 0.0001). Regarding MCA2 values of matched patient groups, similar findings were detected (SPL: p = 0.0013, SRP: p < 0.0001). Sinu-nasal outcome test-20 GAV and NOSE© scores were reduced after both surgical procedures (NOSE©: SPL: p < 0.0001, SRP: p < 0.0001; SNOT-20 GAV: SPL: p = 0.0068, SRP: p < 0.0001). Evaluation of patient satisfaction in a self-established feedback questionnaire revealed a motivation of 81% of patients to redo the surgery (SPL 13/16, SRP 34/42) and a notably general satisfaction of 86% for SPL and 80% for SRP. The authors concluded that rhinosurgery leads improved nasal breathing and increased disease-specific satisfaction quantitatively. Further research with randomized controlled trials is needed to validate these findings.

Sidle, et al, (2019) performed a prospective multicenter case series to examine 12-month outcomes for in-office treatment of dynamic nasal valve collapse (NVC) with a bioabsorbable implant. One hundred sixty-six patients with severe-to-extreme class of Nasal Obstruction Symptom Evaluation (NOSE) scores were enrolled at 16 U.S. clinics (November 2016–July 2017). Patients were treated with a bioabsorbable implant (Latera, Spirox Inc., Redwood City, CA) to support the lateral wall, with or without concurrent inferior turbinate reduction (ITR), in an office setting. NOSE scores and Visual Analog Scale (VAS) were measured at baseline and 1, 3, 6, and 12 months postoperatively. The Lateral Wall Insufficiency (LWI) score was determined by independent physicians observing the lateral wall motion video. Using a disease- specific quality-of-life instrument and objective physical examination, the study shows that an in-office, minimally invasive procedure to stabilize the nasal wall with an absorbable implant significantly improves NAO symptoms in patients with dynamic NVC. The authors concluded that at12 months, the Latera implant is safe and efficacious for selected patients in whom dynamic NVC is a main contributor to their NAO. Longer follow-up is needed to determine efficacy beyond 12 months. Limitation of this study is lack of comparison with a group of participants receiving a treatment other than the Latera implant.

Modica et al. (2018) conducted a study on a sample of 52 patients all followed by the Otolaryngology Unit of the University Palermo between January 2015 and January 2017. The purpose of the study was to determine if functional nasal surgery was effective in moderate to severe OSAS on improving CPAP compliance. The patients in the study all underwent different nasal surgeries (septoplasty, unblocking of lower turbinates, and FESS) and were evaluated 6 months after the surgery using the NOSE scale and evaluating CPAP usage. Most patients following surgery reported an improvement in the degree of obstruction to mild. The results showed by improving nasal function, CPAP usage increased from 2-3 hours a night to 6-8 hours a night with a reduction in CPAP pressure.

Floyd et al. (2017) completed a systematic review and meta-analysis of studies evaluating functional rhinoplasty outcomes with the Nasal Obstruction Symptom Evaluation (NOSE) score. A search by the authors was performed with the terms ‘‘nasal obstruction’’ and ‘‘rhinoplasty.’’ Studies were included if they evaluated the effect of functional rhinoplasty on nasal obstruction with the NOSE score. Case reports, narratives, and articles that did not use the NOSE score were excluded. Functional rhinoplasty was defined as surgery on the nasal valve. The search resulted in 665 articles. After dual-investigator independent screening, 16 articles remained. Study results were pooled with a random effects model of meta-analysis. Change in NOSE score after surgery was assessed via the mean difference between baseline and postoperative results and the standardized mean difference. Heterogeneity was assessed and reported through the I^2 statistic. Patients in the included studies had moderate to severe nasal obstructive symptoms at baseline. The NOSE scores were improved at 3-6, 6-12, and ≥ 12 months, with absolute reductions of 50 points (95% CI, 45-54), 43 points (95% CI, 36-51), and 49 points (95% CI, 39-58), respectively. All these analyses showed high heterogeneity. The authors concluded that nasal obstruction as measured by the NOSE survey is reduced by 43 to 50 points (out of 100 points) for 12 months after rhinoplasty. However, the study is limited due to a heterogeneous patient population, large variability in outcomes beyond 12 months, and the potential for bias in observational studies.

San Nicolo et al. conducted a prospective case series to evaluate the safety and effectiveness of an absorbable implant for lateral cartilage support in subjects with nasal valve collapse (NVC) with 12 months follow-up. Thirty subjects with Nasal Obstruction Symptom Evaluation (NOSE) score ≥ 55 and isolated NVC were treated; 14 cases were performed in an operating suite under general anesthesia and 16 cases were performed in a clinic-based setting under local anesthesia. The implant, a polylactic acid copolymer, was placed with a delivery tool within the nasal wall to provide lateral cartilage support. Subjects were followed up through 12 months post procedure. Fifty-six implants were placed in 30 subjects. The mean preoperative NOSE score was 76.7 ±14.8, with a range of 55 to 100. At 12 months, the mean score was 35.2 ± 29.2, reflecting an average within-patient reduction of - 40.9 ± 31.2 points. The majority (76%) of the subjects were responders defined as having at least one NOSE class improvement or a NOSE score reduction of at least 20%. There were no adverse changes in cosmetic appearance at 12 months post procedure. Three implants in three subjects required retrieval within 30 days post procedure and resulted in no clinical sequelae. The authors conclude that this study demonstrates safety and effectiveness of an absorbable implant for lateral cartilage support in subjects with NVC at 12 months post procedure. Well-designed randomized clinical trials with larger patient populations and longer follow-up periods are needed to further assess absorbable nasal implants. This study is limited by lack of comparison group.

Goudakos et al. (2016) performed a systematic review to assess knowledge and evidence of management options for the treatment of nasal valve collapse. Fifty-three studies were identified and systematically reviewed. The majority (50 of 53) of the included articles were graded as level IV evidence and only one randomized trial was identified. The included randomized study reported no difference in improvement between the intervention group (auto-spreader flap) and placebo arms. Most of the included studies presented in this systematic review provide level IV evidence concerning the optimal approach for cases of nasal valve collapse. At the time of the review, research was driven by reports of techniques rather than patient outcomes. The authors concluded that proper evaluation and identification of the cause of internal valve (INV) collapse is paramount prior to selection of the preferred surgical solution. Treatment approaches should be directed at specific involved sites in the INV and need to be tailored towards the patient's specific problem. This systematic review of the literature revealed that the available evidence is based on low-level studies and focuses more on the description of various surgical techniques rather than on patient-reported outcome measures, the latter of which is recommended in future studies. Further research with randomized controlled trials (RCT) is needed to validate these findings.

Han et al. (2015) developed a clinical consensus statement (CCS) in regard to septoplasty with or without inferior turbinate reduction. A panel was assembled of experts in otolaryngology who performed a systematic literature review to obtain important evidence to support the diagnosis, medical and surgical management of Septoplasty with or without inferior turbinate reduction. A deviated septum is one of the common reasons for nasal obstruction and may or may not involve hypertrophic inferior turbinates. Septoplasty and inferior turbinate reduction aim to improve the nasal airway in these cases. Septoplasty is also used as a supporting procedure to improve access and the function of the paranasal sinuses. The authors noted that there were no clinical guidelines in regard to appropriate methods for diagnoses and treatment of nasal obstruction secondary to septal deviation and turbinate hypertrophy. Payers often require tests such as acoustic rhinometry/rhinomanometry, nasal endoscopy, photos, and imaging despite evidence-based literature prior to approving payment for septoplasty. The panel developed the CCS after evaluating the appropriateness of septoplasty with or without inferior turbinate reduction based on (1) systematic literature review; (2) establishment of active definitions of septoplasty and inferior turbinoplasty, intended scope of practice, and interested people for the consensus statement; (3) modified Delphi survey development and completion; (4) revising clinical statement repeatedly based on survey results; and (5) assembling data, analysis, and presentation. The panel reached an agreement that nasal septoplasty is defined as a procedure used to correct a deviated nasal septum to improve nasal function, form, or both. Determining patients appropriate for septoplasty is based on symptomology and physical examination. The panel reached a strong consensus that anterior rhinoscopy, nasal endoscopy or both are adequate to determine septal deviation and can provide useful information prior to septoplasty. The panel did not determine acoustic rhinometry or rhinomanometry to be helpful in diagnosing septal deviation but can be helpful for patients whose primary issue is nasal obstruction. The panel agreed that photographic evidence is unneeded to confirm septal deviation. The group also determined a nasal steroid trial for 4 weeks prior to septoplasty was adequate conservative treatment.

De Sousa Michels et al. (2014) performed a summary of data and theories on the association between nasal obstruction and obstructive sleep apnea syndrome (OSAS). There are many nose and pharynx abnormalities that can cause snoring and sleep apnea such as rhinitis, turbinate hypertrophy, nasal polyps, and septal deviation. The treatment options for nasal obstructions include nasal dilators, surgical intervention, and medical treatment such as topical corticosteroids and sympathomimetic decongestants. In the context of this article, surgical interventions such as septoplasty, rhinoseptoplasty, functional endoscopic sinus surgery, turbinectomy, and nasal valve surgery appear to be good therapeutic options for patients with nasal obstructions and OSAS. There are patients that may benefit from surgery as an adjuvant treatment to improve the effectiveness of continuous positive airway pressure (CPAP). "Over 50% of CPAP users complain of significant nasal symptoms, such as nasal congestion, rhinorrhea, nasal dryness, and sneezing, which may become more significant if the patient presents any structural abnormality of the nose." Functional or anatomical abnormalities in the nasal cavity may cause patients discomfort and hinder adjustment to the CPAP due to the device requiring higher pressure titration in order to eliminate respiratory events. Studies have shown that patients that had nasal surgery showed a decrease in the levels of CPAP titration. This article has concluded that nasal surgery may be helpful in patients with obstructive sleep apnea (OSA) who do not tolerate CPAP therapy when there is a nasal obstruction present.

Kaufman et al. (2012) performed a literature review regarding various modalities for achieving a successful rhinoplasty for patients with cleft nasal deformity. The cleft nasal deformity presents as a difficult challenge in plastic surgery as it involves skin, mucosa, cartilage, and skeletal platform. Cleft lip nasal surgery can be divided into primary, intermediate, and secondary repairs. Early intervention can be beneficial for an earlier restoration of nasal shape with the increased chance for more symmetrical nasal growth. The primary rhinoplasty is performed with the intention to restore symmetry and reposition nasal structures so that deformities will not be exacerbated by further growth. Some patients may need to have an intermediate rhinoplasty before reaching school age in order to achieve greater symmetry and to help avoid future growth deformities. The best approach to performing a secondary rhinoplasty is to wait until nasal growth has concluded. This deformity is a complex condition that should be addressed during multiple stages of the patient's life to help achieve the best outcome.

Simon and Sidle (2012) performed a literature review of surgical procedures used for augmenting the nasal airway. For patients presenting to otolaryngology clinics, the most common complaint is nasal obstruction. There are a number of different anatomical factors that can contribute to these obstructions and the sensation of decreased nasal airflow. The most common finding in patients with complaints of nasal obstructions is a deviated nasal septum secondary to congenital, traumatic, or iatrogenic etiologies. There are several procedures used to improve these obstructions that fall under the functional rhinoplasty technique such as but not limited to septoplasty, extracorporeal septoplasty, and correction of caudal septal deviation. Septoplasty is usually performed on patients that present with anatomic changes of the septum which may hinder the function of the nasal airway. Extracorporeal septoplasty is usually performed for the more severe deviations or loss of significant portions of the septum which require reconstruction. Caudal septal deviation usually requires treatment beyond traditional septoplasty as these deviations are important on both appearance and functional levels. The caudal septum provides essential structure of the nose and when there is any deviation in these structures, significant deformities may develop. “Previous epidemiological studies have revealed that the finding of a straight septum is present in only 42% of newborns and in adults, only 21%."

A systematic review was completed by Spielmann et al. (2009) to evaluate surgical treatment strategies for nasal valve collapse. The review included 43 articles from 1970 to 2008, with at least 10 patients in each study, stated aim to improve airway obstruction, and a minimum of one month follow-up for every patient. Of these studies, one trial presented level IIIb evidence, and all other studies were classed as level IV. Seven authors present objective measurements of nasal airflow or cross-sectional area, and four authors present validated outcome measures. The authors concluded that there is a variety of focused surgical techniques described which deal with nasal valve collapse. They could find no randomized controlled trials on nasal valve surgery. Research in nasal valve surgery is frequently driven by technical description of surgical technique rather than the establishment of evidence of long-term patient benefit. Although their understanding of the role of the nasal valve in the pathophysiology of nasal obstruction has improved vastly, the myriad of surgical techniques described reflects their uncertainty in choice of technique and in degree of patient benefit. Well designed, adequately powered, prospective, randomized controlled clinical trials of a single surgical technique are needed to further describe safety and clinical outcomes.

Clinical Practice Guidelines

American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS)

A clinical practice guideline developed by the AAO-HNS states that rhinoplasty is often performed to enhance function by improving nasal respiration and relieving congenital or acquired obstruction. The AAO-HNS definition of rhinoplasty documented by Ishii et al. (2017) states that rhinoplasty as a surgical procedure that alters the shape or appearance of the nose while preserving or enhancing the nasal airway. The change in appearance may be a consequence of addressing a functional abnormality (e.g., deviated septum, nasal valve compromise) and for cosmetic purposes (e.g., an incidental cosmetic procedure). The primary reason for surgery can be aesthetic, functional, or both, and it may include adjunctive procedures on the nasal septum, nasal valve, nasal turbinates, or the paranasal sinuses. When these adjunctive procedures are performed without an impact on the nasal shape or appearance, they do not meet the definition of rhinoplasty and are therefore excluded from further consideration in the guideline.

In a 2015 (reviewed 2021) position statement, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) determined that the use of FDA-approved biomaterials can be utilized in sinonasal procedures to improve patient outcomes and reduce complications. These items, such as implants, stents, and packing materials, have functions including, but not limited to, local drug delivery, stenting, and hemostasis. The AAO-HNS does not consider FDA-approved biomaterials for rhinologic application to be investigational and recommends that the final decision regarding use of these biomaterials should be determined by the treating physician, factoring in best available scientific evidence, surgeon experience and the clinical situation, and individual patient preference.

In the 2010 Clinical Consensus Statement by the American Academy of Otolaryngology – Head and Neck Surgery Foundation, Rhee et al. reported that published literature consistently noted the benefit of surgical treatment of nasal valve collapse (NVC), but the evidence relied mostly on uncontrolled studies. The panel generally agreed upon the anatomic and functional features that define NVC and that diagnosis of NVC is best done with history and physical exam findings. The panel found that there is a lack of a “gold standard” objective test for NVC although radiographic tests such as CT or MRI are mainly used to rule out other disease processes such as sinusitis, nasal polyps, and neoplasms. While surgical treatment is the primary mode of treatment of NVC, surgical management was not reviewed by any specific surgical approach but was reviewed broad in scope. The panel met consensus with uniformly strong agreement that a surgical procedure that is targeted to support the lateral nasal wall/alar rim is a distinct entity from procedures that correct a deviated nasal septum or hypertrophied turbinate. There was consensus with agreement that, in some cases, septoplasty and/or turbinate surgery can treat NVC without surgery to support the lateral nasal wall/alar rim. With regards

to medical management of NVC, the panel met consensus that nasal steroid medication is not useful for treating NVC in the absence of rhinitis, and mechanical treatments such as nasal stents may be useful in selected patients.

American Cleft Palate-Craniofacial Association (ACPA)

The ACPA developed standards for the evaluation and treatment of patients with cleft lip/palate or other craniofacial differences under a project funded by the U.S. Public Health Service Department of Health and Human Services. They advise that rhinoplasty and nasal septal surgery are usually advocated only after completion of nasal growth; however, primary rhinoplasty may be done at the time of the primary cleft/lip palate repair surgery depending on the severity of the nasal difference. They further advise that earlier intervention including rhinoplasty and nasal septal surgery may be indicated for reasons of airway problem or nasal tip difference and that the timing of the nasal surgery should be discussed with the patient and parents so that the goals are understood and expectations are realistic (2018).

American Society of Plastic Surgeons (ASPS)

The ASPS published a Nasal Policy Statement (2021) indicating that nasal surgery is considered reconstructive surgery and medically necessary to improve nasal airway function, to treat or revise anatomic abnormalities caused by birth defects or disease, and to revise structural deformities resulting from trauma.

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Policy History/Revision Information

Date	Summary of Changes

09/01/2024	**Template Update**
	• Reformatted and reorganized policy; transferred content to new template
	• Changed policy type classification from "Coverage Summary" to "Medical Policy"
	• Added *Clinical Evidence* and *References* sections
	• Updated *Instructions for Use*
	Related Policies
	• Added reference link to the UnitedHealthcare Commercial Medical Policy titled:
	  ○ *Cosmetic and Reconstructive Procedures*
	  ○ *Lithotripsy for Salivary Stones*
	  ○ *Omnibus Codes*
	  ○ *Rhinoplasty and Other Nasal Procedures*
	  ○ *Sinus Surgeries and Interventions*
	Coverage Rationale
	• Removed content/language addressing:
	  ○ Ethmoidectomy (CPT code 31200)
	  ○ Extensive nasal polypectomy (CPT code 30115)
	  ○ Nasal septal swell body (NSB) reduction (CPT code 30117)
	  ○ Repair of nasal valve collapse with radiofrequency (CPT code 30469)
	  ○ Turbinectomy (CPT codes 30130 and 30140)
	Balloon Sinus Ostial Dilation (Also Known as Balloon Dilation Sinuplasty)
	• Removed reference link to the *Medicare Coverage Database*
	Eustachian Tube Dilation
	• Removed reference link to the *Medicare Coverage Database*
	Functional Endoscopic Sinus Surgery (FESS)
	• Removed reference link to the *Medicare Coverage Database*
	Intranasal Repair
	• Removed reference link to the *Medicare Coverage Database*
	Lithotripsy for Salivary Stones
	• Removed reference link to the *Medicare Coverage Database*
	Posterior Nasal Nerve Ablation Using Radiofrequency or Cryoablation (e.g., Clarifix)
	• Removed reference link to the *Medicare Coverage Database*
	Rhinophototherapy
	• Removed reference link to the *Medicare Coverage Database*
	Rhinophyma Excision
	• Added language to indicate:
	  ○ Medicare does not have a National Coverage Determination (NCD) for rhinophyma excision
	  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist
	  ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Rhinoplasty and Other Nasal Procedures*
	Rhinoplasty
	• Revised guidelines for states/territories with no LCDs/LCAs; replaced reference link to the UnitedHealthcare Commercial Medical Policy titled *Rhinoplasty and Other Nasal Procedures* with instruction to refer to the coverage rationale below:
	  ○ Rhinoplasty is considered reasonable and necessary when there is photographic documentation (all of the following: frontal, lateral, and worm's eye view) of the individual's condition and the procedure is performed for correction or repair of any of the following:
	  ▪ Secondary to trauma, disease, or congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with septoplasty/turbinectomy alone

Date	Summary of Changes
	▪ Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing a functional impairment ▪ Chronic, non-septal, nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves) ○ Rhinoplasty/nasal surgery is not reasonable and necessary when performed for either of the following: ▪ Solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities ▪ As a primary treatment for an obstructive sleep disorder • Removed reference link to the *Medicare Coverage Database* ***Septoplasty*** • Removed reference link to the *Medicare Coverage Database* ***Vestibular Stenosis Repair*** • Revised language pertaining to LCD/LCA availability to indicate LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the *Centers for Medicare & Medicaid (CMS) Related Documents* section of the policy] • Removed reference link to the *Medicare Coverage Database* **Applicable Codes** • Updated list of applicable CPT codes (previously located in the *Coverage Rationale s*ection); removed 30115, 30117, 30130, 30140, 30469, 31200, and 31276 **Centers for Medicare and Medicaid Services (CMS) Related Documents** • Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information **Supporting Information** • Archived previous policy version MCS060.09

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

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. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.