Description of Service

Rhinoplasty is an operation on the nose to correct nasal contour and/or to restore nasal function. Although it is typically performed for cosmetic purposes to correct or improve the external appearance of the nose, there may be situations when it may be considered reconstructive in nature. Nasal deformities may be congenital, (e.g., cleft lip and/or cleft palate) or acquired (e.g., trauma, disease, ablative surgery).

Vestibular stenosis or collapse of the internal valves may be a cause of nasal obstruction. The nasal valve refers to tissue that acts as a bridge between the bony skeleton and the nasal tip and can account for approximately half of the total airway resistance of the entire upper and lower respiratory tract. Nasal valve compromise may account for nasal airway obstruction. The causes of internal nasal valve obstruction may include: previous surgery, trauma, facial paralysis, and cleft lip nasal deformities (Schlosser & Park, 1999).

Septoplasty is the surgical correction of a deformity of the nasal septum, which is the partition that divides the nasal cavity into two chambers. The presence of a septal deformity can be caused by trauma, or it may be congenital (Corey, et al., 2010).

Benefit Application

This medical policy relates only to the services or supplies described herein. Please refer to the member’s benefit booklet for availability of benefits.

The clinical coverage policy for sinus surgery can be found at geha.com.

GEHA considers any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated promptly or as soon as the member’s condition permits, as cosmetic and therefore not a covered benefit.

Management of congenital anomalies for individuals under the age of 18 is described in the member’s benefit booklet and may be applicable to consideration of rhinoplasty.

Policy Statement

GEHA will provide coverage for rhinoplasty when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

GEHA will not provide coverage if the procedure is for cosmetic purposes.

When Rhinoplasty and other nasal reconstructive surgery is covered:
Rhinoplasty (CPT 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462) may be considered medically necessary in the following conditions:

1. For reconstruction following removal of nasal malignancy, destructive inflammatory diseases (e.g., Wegener’s granulomatosis, pleomorphic granulomatosis), congenital conditions such as maxillonasal dysplasia, Binder’s syndrome, facial clefts, abscess or osteomyelitis that has caused severe deformity and breathing difficulty, or
2. When the obstruction cannot be corrected by septoplasty or turbinectomy alone:
   a. For deformities of the bony nasal pyramid (nasal bones and nasal process of the maxilla) that:
      i. Directly cause significant and symptomatic airway compromise, sleep apnea or recurrent or chronic rhinosinusitis, and
      ii. Is not responsive to appropriate medical management. Appropriate medical treatment is defined as 4 weeks or greater of treatment including nasal steroids and immunotherapy, or
   b. Nasal fracture leading to deformity of the bony nasal pyramid severe enough to cause nasal airway obstruction caused by specifically documented trauma, or
   c. For trauma-related nasal airway obstruction leading to chronic rhinosinusitis that is refractory to medical management, regardless of date of injury (MCG, 2019).

Vestibular Stenosis or Alar collapse repair (CPT 30465, 30468) is considered medically necessary when all of the following are present:

1. Chronic nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves); and
2. Demonstration of improvement of the airway by EITHER of the following methods:
   a. Positive Cottle maneuver
   b. Lateralization of the upper lateral cartilage from inside the nose with an object (e.g., cotton swab or nasal speculum); and
3. Color photos clearly document internal and/or external valve collapse as the primary cause of an anatomic mechanical nasal airway obstruction and are consistent with the clinical exam; and
4. Other causes have been ruled out as the primary cause of nasal obstruction (e.g., sinusitis, allergic rhinitis, vasomotor rhinitis, nasal polyposis, adenoid hypertrophy, nasopharyngeal masses, nasal septal deviation, turbinate hypertrophy and choanal atresia)

Absorbable implants are considered experimental/investigational due to insufficient published evidence to assess the safety.

Septoplasty (CPT 30520) is considered medically necessary when performed for ANY of the following indications:

1. Septal deviation causing nasal airway obstruction resulting in prolonged or chronic nasal breathing difficulty or mouth breathing that has proved poorly responsive to a recent trial of conservative medical management (e.g., topical/nasal corticosteroids, antihistamines)
2. Recurrent epistaxis related to a septal deformity
3. Performed in association with a covered cleft lip or cleft palate repair

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4. Obstructed nasal breathing due to septal deformity or deviation that has proved poorly responsive to medical management lasting at least six weeks and is interfering with the effective use of medically necessary continuous positive airway pressure (CPAP) for the treatment of an obstructive sleep disorder (i.e., obstructive sleep apnea with an apnea/hypopnea index (AHI) ≥ 15 as documented by polysomnography or home/portable sleep study)

**When Rhinoplasty is not covered**

1. For change in the external appearance of the nose in the absence of trauma or injury. This is considered cosmetic.
2. For any indication other than the specific clinical circumstances described above as covered.
3. GEHA considers the use of Latera (Spirox) Absorbable Nasal Implant as experimental and investigational. There is insufficient published evidence to assess the safety and/or impact of the Latera Absorbable Nasal Implant on health outcomes or patient management (Hayes, 2016).

**Physician Documentation:**

GEHA may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Rhinoplasty or other nasal surgery documentation should be adequate information to allow assessment of the complete evaluation and management plan regarding the requested surgery. The member’s medical record must contain, and be available for review on request, the following information:

- Physician office notes and/or History and Physical documenting:
  - Duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.; *and*
  - Documentation of results of tried and failed management of symptoms
  - Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener’s granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity)

- Radiologic imaging if done. Specifically, results of nasal endoscopy, CT or other imaging.

- Color photographs (time and date stamped) that document the external nasal deformity including a standard 4-way view: anterior-posterior, right and left lateral views, and base of nose (this view is from the bottom of nasal septum pointing upwards).

**Policy Guidelines**

In 2017 a collaborative cohort of members from the following organizations developed: Clinical Practice Guideline: Improving Nasal Form and Function after Rhinoplasty.

American Academy of Facial Plastic & Reconstructive Surgery (AAFPRS), American Society of Plastic Surgeons (ASPS), American Academy of Sleep Medicine (AASM), American Rhinologic Society (ARS),
Society of Otorhinolaryngology Head-Neck Nurse (SOHN), American Society for Aesthetic Plastic Surgery (ASAPS), American Academy of Pediatrics (AAP), The Rhinoplasty Society

The primary purpose of this guideline is to provide evidence-based recommendations for clinicians who either perform rhinoplasty or are involved in the care of a rhinoplasty candidate, as well as to optimize patient care, promote effective diagnosis and therapy, and reduce harmful or unnecessary variations in care.

Guideline Development Group made the following recommendations: (1) Clinicians should ask all patients seeking rhinoplasty about their motivations for surgery and their expectations for outcomes, should provide feedback on whether those expectations are a realistic goal of surgery, and should document this discussion in the medical record. (2) Clinicians should assess rhinoplasty candidates for comorbid conditions that could modify or contraindicate surgery, including obstructive sleep apnea, body dysmorphic disorder, bleeding disorders, or chronic use of topical vasoconstrictive intranasal drugs. (3) The surgeon, or the surgeon’s designee, should evaluate the rhinoplasty candidate for nasal airway obstruction during the preoperative assessment. (4) The surgeon, or the surgeon’s designee, should educate rhinoplasty candidates regarding what to expect after surgery, how surgery might affect the ability to breathe through the nose, potential complications of surgery, and the possible need for future nasal surgery. (5) The clinician, or the clinician’s designee, should counsel rhinoplasty candidates with documented obstructive sleep apnea about the impact of surgery on nasal airway obstruction and how obstructive sleep apnea might affect perioperative management. (6) The surgeon, or the surgeon’s designee, should educate rhinoplasty patients before surgery about strategies to manage discomfort after surgery. (7) Clinicians should document patients’ satisfaction with their nasal appearance and with their nasal function at a minimum of 12 months after rhinoplasty.

The Guideline Development Group made recommendations against certain actions: (1) When a surgeon, or the surgeon’s designee, chooses to administer perioperative antibiotics for rhinoplasty, he or she should not routinely prescribe antibiotic therapy for a duration >24 hours after surgery. (2) Surgeons should not routinely place packing in the nasal cavity of rhinoplasty patients (with or without septoplasty) at the conclusion of surgery.

The panel group made the following statement an option: The surgeon, or the surgeon’s designee, may administer perioperative systemic steroids to the rhinoplasty patient.

A consensus panel was convened by the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) to create a clinical consensus statement for the diagnosis and management of nasal valve compromise (NVC) (Rhee, et al., 2010). The statement included:

• NVC is a distinct clinical entity for patients who present with symptomatic nasal airway obstruction and is best evaluated with history and physical examination findings.

• Audible improvement in nasal airflow during a Cottle maneuver (manual lateral retraction of the cheek) or manual intranasal lateralization of the lateral nasal wall is consistent with NVC

• Endoscopy and photographs may useful, but are not routinely indicated

• Radiographic studies are not useful in evaluating NVC

• Nasal steroid medication is not useful for treatment of NVC in absence of rhinitis

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• Mechanical treatments (e.g., nasal strips, stents, or cones) may be useful in selected patients

• Surgical treatment is the primary mode of treatment of NVC. The panel met consensus that 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.

**Regulatory Status**

Rhinoplasty is a procedure and, as such, is not subject to regulation by the FDA. However, the FDA does regulate manufacturing and dispensing practices and use of devices and drugs for such procedures.

The Spirox Latera was cleared by the FDA (K161191) for marketing in 2016, as an Absorbable Nasal Implant indicated for supporting nasal upper and lower lateral cartilage.

**Background**

Nasal obstruction is one of the most common problems for physician visits and septal deviation is a frequent structural etiology. Surgical correction of septal deviation is the third most common head and neck procedure performed in the United States. Septal deviation is the most frequently encountered structural malformation causing nasal obstruction.

Underlying deformities of the septum affect or more often dictate the direction of the nasal dorsum. Frequent causes include high septal deflections, cartilaginous or bony fractures and dislocation off the maxillary crest. Traumatic events are a common cause of these deformities (Antunes et.al., 2011).

For a successful surgical correction of nasal obstruction, diagnosing the precise anatomic point of collapse is fundamental. Recognition of the nature and locating of nasal valve, septal and turbinate disorders allows adequate correction and acceptable functional results (Ghosh & Friedman, 2016).

The interference in airflow may also cause middle or inferior turbinate abnormalities. Sinus drainage may also be compromised by deviation of the septum and can result in recurrent or chronic sinusitis. The decision for septoplasty is not typically based solely on the degree of deviation alone, but rather based on the accompanying functional impairment in the form of obstructed nasal breathing and any resulting conditions, such as sinusitis. Generally, a case is considered refractory to medical management when there has been a sufficient period of treatment with antibiotics for infections, intranasal steroids, and decongestants (Mickelson and Benninger, 2001).

In a study by Smith et. al. (2011) outcomes in patients with chronic rhinosinusitis who were treated medically and surgically were compared. Adult subjects were prospectively enrolled into a nonrandomized, multi-institutional cohort. Baseline characteristics and objective clinical findings were collected. Primary outcome measures included 2 disease-specific quality-of-life (QOL) instruments: the Rhinosinusitis Disability Index (RSDI) and Chronic Sinusitis Survey (CSS). Bivariate and multivariate analyses compared QOL improvement by treatment type, as well as differences in antibiotic and oral steroid utilization and work/school productivity. Patients electing medical management reported significantly better baseline QOL on 1 instrument relative to surgery patients. Surgical patients reported significantly more improvement than medically managed patients. Surgical patients reported significantly fewer oral antibiotics, oral steroids, and missed days of work/school following ESS. After adjustment, more frequent improvement was found within the surgical cohort as measured by the RSDI
physical, CSS symptom, medication, and total scores. Patients electing ESS experienced significantly higher levels of improvement in several outcomes. Further investigation with a larger cohort is warranted as treatment selection bias may confound the magnitude of improvement experienced with each treatment.

Rhinoplasty procedures may involve the use of grafts, in particular grafts obtained from the septum (Flint, et al., 2010). Harvested septal cartilage may also be used for spreader grafts for stenting of the internal nasal valve angle or batten grafts for bolstering the valve area during repair of the nasal valves.

Vestibular stenosis is a collapsing of the internal nasal valves that can lead to nasal airway obstruction. Tissue losses within the nose due to various reasons result in the loss of normal anatomy and function. The external nasal valve area is one of the most important functional components of the nose. The columnella, lobule, nostril, and alar region are among the components forming the external nasal valve area. Deformities of the nostrils are among the most frequently observed features that interfere with the functional anatomy of the nose. Malformations of the nostrils often emerge subsequent to cleft lip repairs. Stenosis is a common type of pathology among nostril deformities. In cases where a stenosis has formed, breathing problems and developmental anomalies may occur (Bozkurt et. al., 2012).

The Cottle maneuver is a test used to determine nasal valve integrity. It can be performed by retracting the cheek laterally, pulling the upper lateral cartilage away from the septum and widening the internal nasal valve angle. If the patient’s symptoms are relieved with this maneuver, it suggests that the cause of the nasal airway obstruction is related to the nasal valve area (e.g., dorsal septal deviation, lack of upper lateral cartilage integrity). Another technique to evaluate the nasal valves involves using an object (e.g., cotton swab or nasal speculum) to lateralize the upper lateral cartilage from inside the nose, and the patient is asked if their symptoms are improved. This technique allows direct observation of the nasal valve area as it widens (Chandra, et. al., 2009).

There is insufficient literature found to support septoplasty or rhinoplasty for the primary treatment of obstructive sleep apnea. The exact role that obstructed nasal breathing plays in the cause of sleep disorders remains presumptive, and robust clinical studies are needed. Septoplasty may be considered medically necessary when there is documentation that obstructed nasal breathing due to septal deformity or deviation is causing difficulty tolerating nasal continuous positive airway pressure (CPAP) and it is refractory to medical management. Positive airway pressure (PAP) treatment is considered an effective and widespread treatment of moderate obstructive sleep apnea (Ishii et. al., 2017)(Smith, D. et al., 2015)(Chen & Kushida, 2003).

San Nicoló et al. (2017) reported on a prospective, single cohort, nonrandomized study that evaluated the safety and effectiveness of an absorbable nasal implant with 12 months follow-up. The study included 30 subjects with Nasal Obstruction Symptom Evaluation (NOSE) score 55 and isolated NVC; 14 cases were performed in an operating suite under general anesthesia and 16 cases were performed in a clinic-based setting under local anesthesia. 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. This study is limited by the small number of subjects, lack of a comparator and lack of randomization.

San Nicoló et al. (2018) reported on follow-up of the above study (San Nicoló, et al., 2017) to assess whether the safety and effectiveness of the implant persist in these patients for 24 months after the procedure. Subjects were followed up through 24 months post-procedure. The mean preoperative NOSE score was 76.7 ± 14.8, with a range of 55 to 100. At 24 months, the mean score was 32.0 ± 29.3, reflecting an average within-patient reduction of -44.0 ± 31.1 points. There were no device-related adverse events in the 12 to 24 months period. There were five subjects who exited the study prior to the 24-month follow-up.

A Hayes report (2018) found that there is insufficient published evidence to assess the safety and/or impact of the Latera Absorbable Nasal Implant on health outcomes or patient management.

The following list of codes are intended for reference purposes only, is not an all-inclusive code listing, and does not imply that the service is covered or non-covered. Applicable codes include but are not limited to:

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Definition</th>
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<tbody>
<tr>
<td>30400</td>
<td>Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30410</td>
<td>Complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip</td>
</tr>
<tr>
<td>30420</td>
<td>Rhinoplasty, primary; including major septal repair</td>
</tr>
<tr>
<td>30430</td>
<td>Rhinoplasty, secondary; minor revision (small amount of nasal tip work)</td>
</tr>
<tr>
<td>30435</td>
<td>Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)</td>
</tr>
<tr>
<td>30450</td>
<td>Rhinoplasty, secondary; Major revision (bony work with osteotomies)</td>
</tr>
<tr>
<td>30460</td>
<td>Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only</td>
</tr>
<tr>
<td>30462</td>
<td>Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies</td>
</tr>
<tr>
<td>30465</td>
<td>Repair of nasal vestibular stenosis (spreader grafting, lateral nasal wall reconstruction)</td>
</tr>
<tr>
<td>30468</td>
<td>Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s) {not including absorbable nasal implants}</td>
</tr>
<tr>
<td>30560</td>
<td>Lysis intranasal synechia</td>
</tr>
<tr>
<td>30620</td>
<td>Septal or other intranasal dermatoplasty (does not include obtaining graft)</td>
</tr>
<tr>
<td>30520</td>
<td>Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft</td>
</tr>
</tbody>
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30999  Unlisted procedure, nose (when used to report the insertion of an absorbable nasal implant or radiofrequency of nasal valve)

Scientific References


**Policy implementation and updates**

May 2018  Policy created and implemented.

April 2019  Policy reviewed. Added language to better define clinical criteria. Added language for Latera nasal implant.


Mar 2021  Addition of the following coverage criteria: Septoplasty. Addition of associated descriptions and billing codes.