Medical Policy:
Septoplasty (Commercial)

POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
MG.MM.SU.04	2/14/2025	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

Definitions

Septoplasty	Septoplasty (submucosal resection of the septum) is the surgical correction or reconstruction of the nasal septum, which divides the right and left cavities. The septum is generally situated in the direct center of the nose; however, when the septum is off-center or misaligned, corrective surgery is sometimes required to correct the breathing impairment that results from the misalignment.

Related Guidelines

Cosmetic and Reconstructive Surgery Procedures
Rhinoplasty

Guideline

Members are eligible for coverage of septoplasty when **at least 1** of the following conditions exists:

I. Reconstruction post tumor or polyp removal or surgical excision of part of the ethmoid bone (ethmoidectomy or turbinate reduction).

II. Chronic nasal obstruction attributable to deviated septum that results in significant medical disabilities, such as:

1. **Recurrent purulent sinusitis**[1] (> 3 episodes per year) with clinically significant obstruction. Conservative management has failed to alleviate or prevent episodes of sinusitis, including **all**:
    - Antibiotics
    - Antihistamines, decongestants, nasal sprays or topical steroids
    - Attempts to discontinue nasal irritants such as smoking, drugs and inadequate humidification

2. **Nasal septal deformity or spur (congenital or acquired)** with clinically significant obstruction; **all**:
    - Assessment and testing, if appropriate, for allergic conditions completed
    - Conservative management failure in the presence of allergic rhinitis (i.e., allergic precautions, antihistamines, topical nasal steroids and plus/minus desensitization injections)
    - General conservative management failure (i.e., reduction of all nasal irritants such as smoking, occupational exposures, drugs and inadequate humidification)

3. **Recurrent Epistaxis** (at least 4, or an episode of severe epistaxis associated with a septal deviation or spur seen on exam); **both**:
    - Conservative treatment measure failure, such as avoidance of medications affecting coagulation, addition of environmental humidity and cauterization
    - Nasal spur or septal deformity etiology of abnormal airflow

4. **Unusual facial pain** originating from the nasal area and relieved by septal anesthesia.

[1] Diagnosis must be documented by both of the following: Symptoms (including purulent nasal drainage) and radiologic evidence of either recurrent acute sinusitis (> 3 episodes per year) or chronic rhinosinusitis (symptoms > 12 weeks (clouding of sinuses, thickening of sinus membranes on limited CT).

5. **Impending septal perforation (hole through the septum); both:**
    - Significant septal deviation with airflow obstruction
    - Conservative measure failure, including humidification, desisting further digital trauma, reduction of nasal irritants (smoking, drugs) and drug therapy (decongestants, antihistamines, nasal steroids), if indicated

III. Asymptomatic deformity that prevents surgical access to other intranasal or paranasal areas (e.g., sinuses, turbinates)

IV. When performed in association with cleft palate repair

V. Obstructive sleep apnea (to aid in ability to utilize CPAP and help upper airway obstruction) (Eff. 2/12/2021) (Note: for those members with allergic rhinitis who also have OSA, documentation of conservative management failure in the presence of allergic rhinitis [i.e., allergic precautions, antihistamines, topical nasal steroids and plus/minus desensitization injections] should be submitted)

Limitations/Exclusions

Septoplasty is not considered medically necessary for any indications other than those listed above.
Absorbable nasal implants for the treatment of nasal valve collapse (e.g., Latera® Absorbable Nasal Implant, CPT 30468) are considered investigational for Commercial.

Applicable Procedure Codes

30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)

Applicable ICD-10 Diagnosis Codes

C30.0	Malignant neoplasm of nasal cavity
C31.0	Malignant neoplasm of maxillary sinus
C31.1	Malignant neoplasm of ethmoidal sinus
C31.2	Malignant neoplasm of frontal sinus
C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C41.0	Malignant neoplasm of bones of skull and face
C79.89	Secondary malignant neoplasm of other specified sites
C79.9	Secondary malignant neoplasm of unspecified site
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D16.4	Benign neoplasm of bones of skull and face
G47.30	Sleep apnea, unspecified
G47.31	Primary central sleep apnea
G47.32	High altitude periodic breathing
G47.33	Obstructive sleep apnea (adult) (pediatric)
J32.0	Chronic maxillary sinusitis
J32.1	Chronic frontal sinusitis

J32.2	Chronic ethmoidal sinusitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.0	Polyp of nasal cavity
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	CYST and mucocele of nose and nasal sinus
J34.2	Deviated nasal septum
J34.89	Other specified disorders of the nose and paranasal sinuses
M95.0	Acquired deformity of nose
Q30.3	Congenital perforated nasal septum
Q30.8	Other congenital malformations of the nose
R04.0	Epistaxis
R09.81	Nasal congestion

References

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Specialty-matched clinical peer review.

Revision History

Company(ies)	DATE	REVISION
ConnectiCare	Feb. 14, 2025	Transferred policy content to individual company branded template
ConnectiCare EmblemHealth	Jan. 19, 2023	Added documentation note pertaining to obstructive sleep apnea indication
ConnectiCare EmblemHealth	Nov. 12, 2021	Added obstructive sleep apnea (to aid in ability to utilize CPAP and help upper airway obstruction) as a covered indication (eff. 2/12/2022)
ConnectiCare	Jun. 1, 2021	Added investigational language for absorbable nasal implants to Limitations/Exclusions section.
EmblemHealth	Sept. 14, 2018	Substituted language pertaining to "50 percent obstruction" for sinusitis and nasal deformity with "clinically significant obstruction".
EmblemHealth	Aug. 12, 2016	Added septoplasty coverage when performed with cleft palate repair, as well as when an asymptomatic deformity impacts surgical access to other intranasal/paranasal areas.