Policy No.	CLP-7.9	Effective Date:	10.22.2024
Policy Name	Nasal Surgery	Last Review Date:	10.24.2023
		Last Revision Date:	10.22.2024
Prior Auth	Yes	Origination Date:	01.08.2001

Definition:

This policy addresses multiple types of nasal surgeries including: treatment of fractures, rhinoplasty, reconstructive and cosmetic surgeries.

Rhinoplasty: a surgical procedure of the nose to correct an external nasal deformity, damaged nasal structures, or replace lost tissue while maintaining or improving the physiological function of the nose.

Septoplasty: a surgical procedure to correct anatomic deformity or deviation of the nasal septum.

Balloon Ostial Dilation: a procedure in which the frontal, sphenoid, or maxillary sinus ostium is dilated or the ethmoid infundibula is pushed aside using a balloon catheter.

Policy:

1. Discussion
- **A.** The reasons for nasal surgery may be broadly classified as:
  - **a.** Cosmetic – to improve appearance without functional impairment
  - **b.** Medically necessary – to correct the cause of a clinically significant functional impairment, for example:
    - **i.** Airway obstruction
    - **ii.** Chronic sinusitis secondary to occluded ostium
    - **iii.** Recurrent epistaxis
- **B.** PHP does not ordinarily offer coverage for cosmetic surgery. There may be circumstances, however, when the medically necessary improvement or function can secondarily result in cosmetic improvement (e.g., correction of a severely deformed obstructing septum causing improvement of the external nasal contour). PHP generally considers rhinoplasty a cosmetic procedure (except as noted below), and therefore not covered.
- **C.** Each request for coverage must be reviewed based upon the primary reason given by the clinician for the proposed surgery. Reconstructive procedures following primary healing of a nasal fracture (five weeks after initial injury) should be individually reviewed for medical necessity.

2. Procedure Coverage
- **A.** Closed and open treatment of nasal bone fracture(s) is considered medically necessary when the proposed treatment is reconstructive and acute (< five weeks after initial injury), initial care.
- **B.** Rhinoplasty
  - **a.** Rhinoplasty is considered cosmetic and generally not covered; however, rhinoplasty is considered medically necessary for any of the following indications:
    - **i.** Correction or repair of a nasal deformity secondary to a cleft lip/palate or other severe congenital craniofacial deformity that is causing a functional impairment (i.e., nasal obstruction, inadequate airflow, feeding difficulties) when bother of the following criteria are met:
      - **(a)** Photographic evidence of the anatomical abnormality
      - **(b)** The functional impairment is expected to be resolved by the rhinoplasty

ii. Correction or repair of a nasal deformity secondary to trauma that is causing a functional impairment (i.e., nasal obstruction, inadequate airflow) and all of the following criteria are met:
- **(a)** Nasal airway obstruction is poorly responsive to a recent six-week trial of conservative medical management (i.e., topical/nasal corticosteroids, antihistamines)
- **(b)** Photographic evidence of the anatomical abnormality
- **(c)** The functional impairment has either not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with a septoplasty/turbinectomy alone
- **(d)** The functional impairment is expected to be resolved by the rhinoplasty

b. Rhinoplasty revision is considered cosmetic and generally not covered; however, it is considered reconstructive and medically necessary when **ALL** of the following criteria are met:
- **i.** Required for treatment of complications or a residual deformity from a primary surgery performed to address the Functional Impairment when documentation supports the persistence of the functional impairment due to the complication or deformity; **and**
- **ii.** Photographs clearly document the secondary deformity or complication as the primary cause for an anatomic Mechanical Nasal Airway Obstruction which correlates with a clinical exam; **and**
- **iii.** The proposed procedure is to correct the anatomical Mechanical Nasal Airway Obstruction and relieve the nasal airway obstruction by correcting the deformity or complication; **and**
- **iv.** Nasal airway obstruction is causing significant symptoms (chronic rhinosinusitis, difficulty breathing); **and**
- **v.** Obstruction symptoms persist despite conservative management for 4 weeks or greater (ie: nasal steroids, immunotherapy)

C. Septoplasty

a. Septoplasty is considered medically necessary when performed for any of the following indications:
- **i.** Septal deviation causing nasal airway obstruction resulting in prolonged or chronic nasal breathing difficulty or mouth breathing not responding to 4 or more weeks of appropriate medical therapy (i.e., topical/nasal corticosteroids, antihistamines)
- **ii.** Recurrent epistaxis related to a septal deformity
- **iii.** Performed in association with a covered cleft lip or cleft palate repair
- **iv.** Obstructed nasal breathing due to a septal deformity or deviation that has proved poorly responsive to medical management and is interfering with the effective use of medically necessary CPAP for the treatment of an obstructive sleep disorder
- **v.** Asymptomatic septal deviation which prevents access to other intranasal areas when required to perform medically necessary surgical procedures (ie: ethmoidectomy)

D. Ballon Sinus Ostial Dilation (also called balloon sinusplasty)

a. Balloon sinus ostial dilation is considered medically necessary in each of the sinuses being considered for dilation for the treatment of chronic sinusitis when **ALL** of the following criteria are met:
- **i.** Presence of **two or more** of the following for more than 12 weeks:
  - **(a)** Nasal obstruction
  - **(b)** Anterior or posterior foul drainage
  - **(c)** Facial pain, pressure and/or fullness over the affected sinus
  - **(d)** Decreased sense of smell
- **ii.** Evidence of chronic rhinosinusitis on CT scan in the sinus(es) being considered for treatment including any of the following:
  - **(a)** Mucosal thickening > 3mm
  - **(b)** Air fluid levels
  - **(c)** Opacification
  - **(d)** Air bubbles

(e) Pansinusitis

iii. Documentation of failure, intolerance or contraindication of medical management with trial of **ALL** of the following during at least 8 consecutive weeks:

(a) At least two different full courses of antibiotics

(b) Steroid nasal spray

(c) Antihistamine nasal spray

(d) Nasal lavage

b. Balloon sinus ostial dilation performed as an adjunctive procedure during functional endoscopic sinus surgery (FESS), in the same sinus cavity, is considered to be an integral part of the primary procedure.

i. Balloon sinus ostial dilation is limited to the frontal, maxillary or sphenoid sinuses.

ii. Balloon sinus ostial dilation is unproven and not medically necessary for treating nasal polyps or tumors due to insufficient evident of efficacy.

c. Balloon Sinus Ostial Dilation for treatment of recurrent acute rhinosinusitis is considered medically necessary when **ALL** of the following criteria are met:

i. Documentation of 4 or more episodes per year of acute rhinosinusitis

ii. CT scan with findings consistent with ostial occlusion and mucosal thickening in each paranasal sinus being considered for treatment

iii. Sinonasal symptoms (ie: pain, pressure, drainage, reduced sense of smell)

E. Experimental and investigational and/or not medically necessary:

a. Repair of nasal valve collapse with absorbable nasal implant(s)

b. Nasal valve suspension for the repair of nasal valve collapse

c. Radiofrequency of nasal valve for the treatment of nasal airway obstruction

d. Extracorporeal septoplasty for revision of deviated septum

e. Ballon dilation septoplasty for treatment of septal deviation

f. Septoplasty for any indication not listed above (ie: allergic rhinitis)

g. Rhinoplasty when performed for any of the following indications is considered cosmetic in nature and/or not medically necessary:

i. Solely for the purpose of changing appearance

ii. As a primary treatment for an obstructive sleep disorder

iii. Performed as part of gender reassignment

h. Any other reasons not listed above

Associated Medical Policies:

16.12 Congenial Defects and Birth Abnormalities
17.5 Cosmetic Surgery – Coverage Determination

Associated Documents: N/A

Primary Source / Clinical References:

PHP member contract
Hayes, Inc, Balloon Sinuplasty for Treatment of Chronic Rhinosinusitis reviewed 09.30.2022
Cigna Coverage Policy Number 0480 effective: 04.15.2024
Cigna Coverage Policy Number 0119 effective: 06.15.2024
Aetna Clinical Policy Bulletin Number 0937 effective: 05.15.2024
Aetna Clinical Policy Bulletin Number 0005 effective: 03.19.2024
UHC Medical Policy 2023T0571O effective: 10.01.2023
UHC Medical Policy MP.019.30 effective: 07.01.2024

Anthem Guideline CG-SURG-18 effective: 04.10.2024
Anthem Guideline CG-SURG-73 effective: 06.28.2024
Anthem Document SURG.00079 effective: 09.27.2023
Anthem Medical Policy ANC.00008 effective: 04.10.2024

Medical Director Signature of Approval