Policy Number: CP-AMCR24-004A

Effective Date: January 1, 2024

Septoplasty

The purpose of this policy is to provide clarity and specificity for coverage of Septoplasty.

This policy does not apply to services involving the management of birth defects for cleft lip or cleft palate repair.

DISCLAIMER

Coverage Policies are developed to assist in identifying coverage for Aspirus benefits under Aspirus's health plans. They are intended to serve only as a general reference regarding Aspirus's administration of health benefits and are not intended to address all issues related to coverage for health services provided to Aspirus members.

These services may or may not be covered by all Aspirus products (refer to product section of individual coverage policy for product-specific detail). Providers are encouraged to have their Aspirus patient refer to their Aspirus plan documents (Evidence of Coverage/Member Handbook/Member Contract) for specific coverage information. If there is a conflict between a coverage policy and the Aspirus plan documents, the Aspirus plan documents prevail.

Medicare products may provide different coverage for certain services, which may be addressed in different policies. For Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and/or Local Coverage Articles, please consult CMS, National Government Services, or CGS websites.

Coverage Policies do not constitute medical advice. Providers are responsible for submission of accurate and compliant claims.

Product Summary

This coverage policy applies to the following Aspirus products:

Aspirus product	Applies to
Aspirus Medicare Advantage Elite (PPO)	✓
Aspirus Medicare Advantage Essential Rx (PPO)	✓

Benefit category:

Outpatient Surgery

Definitions or summary

- **Deviated septum-**exists when the bone and cartilage of the nasal septum is out of alignment/crooked due to an injury or deformity that blocks one or both nostrils and impairs breathing.

- **Septoplasty**- surgical correction of defects and deformities of the nasal septum (partition between the nostrils) by altering, splinting, or removing obstructive tissue while maintaining or improving the physiological function of the nose.

- **Rhinoplasty**-surgery that changes the shape of the nose and results in changes in the appearance of the nose. May be performed for functional or cosmetic reasons.

- **Septorhinoplasty**-repair of the nasal septum to open the nasal passages by straightening the septum, combined with functional rhinoplasty to correct various breathing constriction issues due to weak nasal walls, nasal valve deformities or previous trauma. Changes in the appearance of the nose may occur but the primary purpose of the procedure is to improve breathing and correct deformities.

Coverage policy

COVERED

- Septoplasty for a deviated septum is covered when deviation causes continuous nasal airway obstruction resulting in nasal breathing difficulty.
- Repair of vestibular stenosis

See CPT/HCPCS/ICD-10 Codes for procedure code that are covered.

NON-COVERED

- Cosmetic surgery to improve or change appearance (other than reconstructive surgery) that is not necessary to treat a related illness or injury.
- Rhinoplasty (alone) to change the appearance of the nose.

CPT/ HCPCS/ICD-10 Codes		
*Note: If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. This list may not be all-inclusive.		
CPT®, HCPCS or ICD-10 CODES	**Modifier**	**Narrative Description**
30520		Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft.
30465		Repair of vestibular stenosis (e.g., spreader grafting, lateral nasal was reconstruction)

*CPT is a registered trademark of the American Medical Association.

Prior authorization
Prior authorization is **not** required for Septoplasty or repair of vestibular stenosis, or deviated septum when deviation causes continuous nasal airway obstruction resulting in nasal breathing difficulty.
Septorhinoplasty and Rhinoplasty are considered cosmetic procedures and require prior authorization through Aspirus Medical Services.

Related policies and documentation	
References to other policies or documentation that may be relevant to this policy	
Policy Number	**Policy Description**
None	

References and source documents
Links to the Aspirus contracts, Center for Medicare and Medicaid Services (CMS), and other relevant documents used to create this policy
Aspirus Elite Medicare Evidence of Coverage (EOC)
Aspirus Essential Rx Medicare Evidence of Coverage (EOC)

Coverage policy development and revision history		
Version	**Date**	**Note(s)**
V1	8/1/2024	New policy Aspirus