

BSC7.19 Nasal Septoplasty	
Original Policy Date: May 1, 2025	Effective Date: May 1, 2025
Section: 7.0 Surgery	Page: Page 1 of 7

Policy Statement

- I. Nasal septoplasty may be considered **medically necessary** when performed for **any** of the following indications:
 - A. Performed in association with cleft lip or cleft palate repair
 - B. Recurrent epistaxis (4 or more significant episodes) related to a nasal septal deviation or deformity
 - C. Recurrent sinusitis (4 or more episodes in a year) caused by deviated septum that is not responsive to appropriate medical and antibiotic therapy
 - D. Airway obstruction caused by nasal septum deformity, proven to be unresponsive to a trial of conservative medical management lasting at least 6 weeks (e.g., topical nasal corticosteroids, decongestants, antibiotic, allergy evaluation and therapy, etc.)
 - E. Nasal breathing obstructions, proven to be unresponsive to medical management and prevents the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder
 - F. Access to other trans nasal areas is obstructed due to asymptomatic septal deviation or deformity when such access is required to perform a medically necessary procedure
- II. Balloon dilation septoplasty for treatment of septal deviation is considered **investigational**.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Sinusitis may be classified as:

- Acute- completely resolved in less than 30 days
- Subacute- completely resolved in 30 to 90 days
- Recurrent- 4 or more discrete acute episodes per year, each completely resolved in less than 30 days but recurring in cycles, with at least 10 days between complete resolution of symptoms and initiation of a new episode⁴

Coding

See the [Codes table](#) for details.

Description

Septoplasty is a procedure used to correct deformities of the nasal septum which can often cause issues with airflow and difficulty breathing.¹ The primary indication for this functional (as opposed to purely aesthetic) surgery is usually septal deviation resulting in significant and symptomatic nasal airway obstruction. Many surgical techniques and approaches have been described; these include endonasal, endoscopic and open procedures. Septoplasty can also be performed alongside or in addition to rhinoplasty, turbinoplasty, or as part of functional endoscopic sinus surgery to improve surgical exposure and access. Operative recovery usually lasts a few weeks, and serious complications are rare. Appropriate patient selection is crucial to maximizing patient outcomes.²

Related Policies

- Balloon Ostial Dilation for Treatment of Chronic and Recurrent Acute Rhinosinusitis
- Functional Endoscopic Sinus Surgery for Chronic Rhinosinusitis

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do **either** of the following:

- Create a normal appearance to the extent possible
- Improve function

Rationale

Nasal septal deviation is a prevalent problem that can have significant quality of life ramifications. Septoplasty is commonly performed to provide qualitative and quantitative benefit to those with nasal obstruction owing to septal deviation. Although a standard, basic technique is often adequate for individuals with mild to moderate mid to posterior septal deviation, unique challenges arise with caudal septal deviation. Herein, multiple strategies that attempt to address anterior septal deviation are discussed. Anterior septal reconstruction has been shown to be a safe and effective means by which to address severe caudal septal deviation and long-term reduction in preoperative symptoms.³

Critical to performing a successful septoplasty is a thorough understanding of the anatomy of the nose, specifically the nasal septum. The septum is the main foundational structure of the external nose, providing support to the nasal dorsum, the columella, and the nasal tip. It also separates the nasal cavity, creating two distinct nasal passages that enable laminar airflow and warm and humidify the inspired air. Deviation of the septum can reduce the cross-sectional area of the nasal valve, which subsequently leads to airway obstruction. This can create symptoms of nasal blockage and, in some circumstances, worsen the symptoms of obstructive sleep apnea. Bony spurs resulting from septal deviation may result in epistaxis, headaches ("Sluder syndrome" or rhinogenic headache), and facial pain.²

There were 10 evidence-based recommendations created based on Grade B and C quality of evidence with overall prevalence of benefit over harm. (1) Clinicians should ask all patients about their motivation for surgery and expectations and outcomes. (2) Candidates should be assessed for comorbid conditions that could impact surgery. (3) The rhinoplasty candidate should be evaluated for nasal airway obstruction during the preoperative assessment. (4) Candidates should be educated regarding what to expect after surgery and any potential complications. (5) Candidates should be

counseled about the impact of surgery on nasal airway obstruction and how sleep apnea might affect perioperative management. (6) The patient should be educated about strategies to manage pain and discomfort after surgery. (7) Perioperative antibiotics for rhinoplasty should not be routinely prescribed for more than 24 hours after surgery. (8) Perioperative systemic steroids have the option to be administered to the rhinoplasty patient. (9) Packing should not be routinely used in the nasal cavity of rhinoplasty patients at the conclusion of surgery. (10) Clinicians should document patient satisfaction with nasal appearance and function at a minimum of 12 months after surgery.

Included within this guideline were validated patient-outcome tools used to perform functional assessments for rhinoplasty. These tools included Nasal Obstruction Septoplasty Effectiveness (NOSE) scale and Sino-Nasal Outcome Test (SNOT-22). Useful tools for evaluating the nasal septums and turbinates preoperatively included anterior rhinoscopy, nasal endoscopy, Cottle maneuver and modified Cottle maneuver. Anterior rhinoscopy is helpful for assessing the nasal septum and turbinates. For patient with no obvious cause for nasal obstruction using anterior rhinoscopy, nasal endoscopy can be valuable. Nasal endoscopy can be useful to evaluate the posterior septum, the ostiomeatal complex, any possible nasal polyps or purulent drainage, the posterior choanae, adenoidal hypertrophy, and the existence of any tumors. Static and dynamic inspection, palpation and the modified Cottle maneuver can be used to supplement physical examination for evaluating the internal nasal valve and external nasal valve for nasal valve collapse. For evaluating the extent of septal deviation, turbinate hypertrophy, and nasal deformity, imaging studies are not useful and should not be performed.

Simon and Sidle 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 many different anatomical factors that can contribute to these obstructions and the feeling of decreased nasal airflow. Nasal septum deviation secondary to congenital, traumatic, or iatrogenic etiologies was the most common finding in patients with complaints of nasal obstructions. These authors too found that the NOSE scale or SNOT-22 test should be used to identify the patient's complaint. The preoperative assessment ought to include anterior rhinoscopy for evaluating septal deviation, nasal endoscopy for any possible tumors, Cottle maneuvers and external dilators to assess and determine dynamic valve collapse and also trials of decongestants for evaluating if mucosal congestion is contributing to the nasal obstruction. 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.

Han et al developed a clinical consensus statement (CCS) in regards 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.

Kaufman et al performed a literature review regarding various modalities for achieving a successful rhinoplasty for patient 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 intermediate rhinoplasty before reaching school age in order to achieve greater symmetry and to help avoid further growth deformities. The best approach for a secondary rhinoplasty surgery is to wait until basal growth is completed. The deformity is complex and should be addressed during multiple stages of the patient's life to assist in reaching the best outcome.

Modica and colleagues 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.¹

References

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD). Cosmetic and Reconstructive Surgery. Accessed April 4, 2025 from <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39051&ver=10&keyword=conservative%20management&keywordType=starts&areald=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1>
2. National Library of Medicine. National Center for Biotechnology Information. Septoplasty. Accessed April 4, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK567718/>
3. National Library of Medicine. National Center for Biotechnology Information. Septoplasty: Basic and Advanced Techniques. Accessed April 4, 2025. <https://pubmed.ncbi.nlm.nih.gov/28340647/>
4. Merck Manual Professional Version. Sinusitis. Accessed April 4, 2025. <https://www.merckmanuals.com/professional/ear-nose-and-throat-disorders/nose-and-paranasal-sinus-disorders/sinusitis>

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:

- Clinical findings (i.e., pertinent symptoms and duration)
- Comorbidities
- Activity and functional limitations
- Family history, if applicable
- Reason for procedure/test/device, when applicable
- Pertinent past procedural and surgical history
- Past and present diagnostic testing and results
- Prior conservative treatments, duration, and response
- Treatment plan (i.e., surgical intervention)
- Consultation and medical clearance report(s), when applicable
- Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
- Laboratory results
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed
- Procedure report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	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)
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
05/01/2025	New policy.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to

treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE	AFTER
<p>New Policy</p> <p>Policy Statement: N/A</p>	<p>Nasal Septoplasty BSC7.19</p> <p>Policy Statement:</p> <ul style="list-style-type: none"> I. Nasal septoplasty may be considered medically necessary when performed for any of the following indications: <ul style="list-style-type: none"> A. Performed in association with cleft lip or cleft palate repair B. Recurrent epistaxis (4 or more significant episodes) related to a nasal septal deviation or deformity C. Recurrent sinusitis (4 or more episodes in a year) caused by deviated septum that is not responsive to appropriate medical and antibiotic therapy D. Airway obstruction caused by nasal septum deformity, proven to be unresponsive to a trial of conservative medical management lasting at least 6 weeks (e.g., topical nasal corticosteroids, decongestants, antibiotic, allergy evaluation and therapy, etc.) E. Nasal breathing obstructions, proven to be unresponsive to medical management and prevents the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder F. Access to other trans nasal areas is obstructed due to asymptomatic septal deviation or deformity when such access is required to perform a medically necessary procedure II. Balloon dilation septoplasty for treatment of septal deviation is considered investigational.