Clinical UM Guideline

Subject:	Septoplasty		
Guideline #:	CG-SURG-18	**Publish Date:**	04/13/2022
Status:	Reviewed	**Last Review Date:**	02/17/2022

Description

This document addresses indications for septoplasty. This document may also be used to review the septoplasty component of procedures which combine both rhinoplasty and septoplasty (that is, rhinoseptoplasty). Medically necessary criteria for the rhinoplasty component of the combined procedure and relevant coding instructions can be found in ANC.00008 Cosmetic and Reconstructive Services of the Head and Neck.

Note: Please see the following related documents for additional information:

- ANC.00008 Cosmetic and Reconstructive Services of the Head and Neck
- SURG.00079 Nasal Valve Repair
- SURG.00096 Surgical and Ablative Treatments for Chronic Headaches
- CG-SURG-87 Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring

Clinical Indications

Medically Necessary:

Nasal septoplasty is considered **medically necessary** for either of the following conditions when an appropriate and reasonable trial of conservative management (which might include use of topical nasal corticosteroids, decongestants, antibiotics, allergy evaluation and therapy, etc.) has failed.

- Symptomatic septal deviation or deformity resulting in **one or more** of the following:
  - Distressing symptoms of nasal obstruction with documented absence of other causes of obstruction likely to be responsible for the symptoms (for example, nasal polyps, tumor, etc.); **or**
  - Persistent or recurrent epistaxis; **or**
  - Chronic recurrent sinusitis

or

- Asymptomatic deformity that prevents surgical access to other intranasal or paranasal areas (for example, sinuses, turbinates).

Not Medically Necessary:

Septoplasty is considered **not medically necessary** when the above criteria are not met and for all other indications including, but not limited to, the following:

- For asymptomatic septal deviation when there is no need for surgical access; **or**
- In the absence of an appropriate and reasonable trial of conservative medical management of symptoms; **or**
- When another condition likely to be causing the obstruction is present (for example, nasal polyp, tumor, etc.); **or**
- For snoring, in the absence of one or more symptoms or conditions indicated as medically necessary.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. 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.

When services may be Medically Necessary when criteria are met:

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)

ICD-10 Procedure	
09BM0ZZ	Excision of nasal septum, open approach
09BM3ZZ	Excision of nasal septum, percutaneous approach
09BM4ZZ	Excision of nasal septum, percutaneous endoscopic approach
09SM0ZZ	Reposition nasal septum, open approach
09SM4ZZ	Reposition nasal septum, percutaneous endoscopic approach
09TM0ZZ	Resection of nasal septum, open approach
09TM4ZZ	Resection of nasal septum, percutaneous endoscopic approach

ICD-10 Diagnosis	
J32.0-J32.9	Chronic sinusitis
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	Cyst and mucocele of nose and nasal sinus
J34.2	Deviated nasal septum
J34.81-J34.89	Other specified disorders of nose and nasal sinuses
Q67.4	Other congenital deformities of skull, face and jaw
R04.0	Epistaxis
S02.2XXA-S02.2XXS	Fracture of nasal bones

When services are Not Medically Necessary:
For the procedure and diagnosis codes listed above when criteria are not met or for all other diagnoses not listed; or when the code describes a situation designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Septoplasty is a surgical procedure performed to correct airway obstruction related to the nasal septum. These obstructions can be caused by structural deformity, disease or trauma.

Deviation of the nasal septum is a common cause for nasal obstruction. Septal deviation occurs when the septum, which divides the two sides of the nasal cavity, is displaced from a straight vertical alignment causing blockage of airflow through one or both sides of the nose. The change in airflow can contribute to mucosal drying leading to

epistaxis and sinusitis. Sinusitis can be acute; meaning the symptoms occur for less than 4 weeks, or it can be chronic which means symptoms last for longer than 12 weeks. The Centers for Disease Control and Prevention (CDC) estimates sinusitis affects more than 28.9 million adults in the United States.

Frequently these conditions respond to medical treatment such as antibiotics and steroid therapy. When medical management is not successful, a septoplasty may be considered. This surgical procedure, usually performed under local or general anesthesia, corrects nasal septum defects or deformities by alteration, splinting, or partial removal of obstructing structures. Septoplasty is usually done to improve breathing, but it also may be performed to assist in the management of polyps, tumors or epistaxis.

Moore and Eccles (2011) reported on a review of 14 articles in which nasal airflow was measured before and after septoplasty due to nasal obstruction because of septal deviation. The articles were limited to those with surgery on the nasal septum (including septoplasty, submucous resection and septal deviation corrective surgery) and articles with different forms of objective measurement of nasal airflow including rhinomanometry, acoustic rhinometry and peak nasal inspiratory flow. The 14 articles included 536 participants and all showed "objective evidence that septal surgery improves nasal patency."

In a 2019 open, multicenter, pragmatic, randomized controlled trial in the Netherlands, van Egmond and colleagues reported on individuals who had nasal obstruction, a deviated septum, and an indication to have septoplasty. The participants were randomly assigned (1:1) to receive either septoplasty (n=102) with or without concurrent turbinate surgery or non-surgical treatment (n=101). The primary objective of the study was to assess the effectiveness of septoplasty when compared to nonsurgical treatment of nasal obstruction in adults using the self-reported Glasgow Health Status Inventory (GHSI). Secondary objective outcomes included nasal patency measured by peak nasal inspiratory flow (PNIF) and 4-phase rhinomanometry (4PR). Secondary subjective outcomes included the Nasal Obstruction Symptom Evaluation (NOSE) scale, sino-nasal outcome test-22 (SNOT-22), the three-level EuroQol, five dimensions (EQ-5D-3L), and Glasgow Benefit Inventory (GBI). Participants were included if there was a primary diagnosis of nasal obstruction as the main indication for septoplasty. Participants were excluded if the primary indication for septoplasty was based on concurrent complaints such as sleep disorders, headaches, or impairment of normal sinus drainage. Other exclusions included history of nasal septal surgery, untreated allergic rhinitis or allergic rhinitis unresponsive to medical treatment, septal perforation, or if the septoplasty was being done as part of a cosmetic rhinoplasty or in participants with a cleft lip or palate. For those in the non-surgical treatment group, there was no pre-specified treatment regimen. The decision between watchful waiting and medical treatment (usually local corticosteroids) was made on an individual basis. The median duration of nasal obstruction before trial entry was 7 years, and most participants (79% in the septoplasty group; 86% in the non-surgical management group) had received previous treatment for nasal obstruction. Primary analysis was done at 12 months on 94 participants who had septoplasty and 95 participants who had non-surgical treatment. In the septoplasty group, GHSI mean score was 72.2, NOSE score was 67.5, SNOT-22 score was 76.8, EQ-5D-3L utility score was 0.89, EQ-5D-3L VAS score was 74.0, PNIF before decongestion was 124.3, PNIF after decongestion was 133.0. In the non-surgical group, GHSI mean score was 63.9, NOSE score was 49.6, SNOT-22 score was 67.0, EQ-5D-3L utility score was 0.87, EQ-5D-3L VAS score was 74.9, PNIF before decongestion was 95.0, PNIF after decongestion was 109.7. Overall 4PR differences were small and less consistent than were the results from PNIF. For the participants in the non-surgical treatment group, if complaints persisted during the 24 months of follow-up, they were able to cross-over to the surgical group and monitored as planned. A total of 30% of the participants did cross over. Due to the nature of the trial (surgery versus non-surgical arm), masking was not possible. Participants were followed for a total of 24 months and benefits (both objective and subjective) continued. The authors conclude that the trial:

Shows that many patients, despite medical treatment, continue to live with nasal obstruction for years before being referred to the ear, nose, and throat surgeon. In these patients, septoplasty offered considerable subjective and objective benefits compared with non-surgical management, which were sustained up to 24 months of follow-up.

A 2021 retrospective case series by Law and colleagues sought to determine if mean NOSE scores at 1 month post septoplasty with inferior turbinate reduction were similar to scores at greater than 6 months postoperatively. Participants were included if they had symptoms of nasal obstruction due to septal deviation with no resolution of symptoms following a greater than 1 month trial of topical intranasal corticosteroids, or intranasal or oral anti-histamines. NOSE scores were collected preoperatively, at 1 month and 6 months following surgery. With 98 participants included, mean NOSE score preoperatively was 72.1, 1 month was 17.1, and 6 months was 12. All participants had significant reductions in NOSE score from preoperative time to 6 months postoperatively, although the reductions were not statistically significant between 1 and 6 months postoperative. While limitations include the retrospective design and procedures performed by two surgeons with differing techniques, NOSE scores showed improvement following septoplasty and inferior turbinate resection for septal deviation after failed conservative treatment.

A 2020 Clinical Practice Guideline by the American Academy of Otolaryngology/Head and Neck Surgery for nosebleed (epistaxis) notes that septoplasty can be done in individuals with recurrent nosebleeds and septal deviation stating "control of bleeding likely from some combination of improved nasal airflow, interruption of mucosal vasculature, and/or more effective packing."

Clinical trials are in progress to assess the effect of conservative management versus septoplasty for septal deviation with nasal obstruction.

Definitions

Epistaxis: Nose bleeding.

Rhinoseptoplasty: A surgical procedure, also referred to as a septorhinoplasty, performed on the nose and the nasal septum (cartilage and bony structure that separates the two nostrils).

Septoplasty: A surgical procedure intended to repair the nasal septum.

Sinusitis: Inflammation of the sinuses.

References

Peer Reviewed Publications:

1. Law RH, Bazzi TD, Van Harn M, et al. Predictors of long-term nasal obstruction symptom evaluation score stability following septoplasty with inferior turbinate reduction. Laryngoscope. 2021; 131(7):E2105-E2110.
2. Lawrence R. Pediatric septoplasty: a review of the literature. Int J Pediatr Otorhinolaryngol. 2012; 76(8):1078-1081.
3. Moore M, Eccles R. Objective evidence for the efficacy of surgical management of the deviated septum as a treatment for chronic nasal obstruction: a systematic review. Clinical Otolaryngology, 2011; 36(2):106-113.

4. Sedaghat AR, Busaba NY, Cunningham MJ, Kieff DA. Clinical assessment is an accurate predictor of which patients will need septoplasty. Laryngoscope. 2013; 123(1):48-52.
5. Stewart MG, Smith TL, Weaver EM, et al. Outcomes after nasal septoplasty: results from the Nasal Obstruction Septoplasty Effectiveness (NOSE) study. Otolaryngol Head Neck Surg. 2004; 130(3):283-290.
6. van Egmond MMHT, Rovers MM, Hannink G, et al. Septoplasty with or without concurrent turbinate surgery versus non-surgical management for nasal obstruction in adults with a deviated septum: a pragmatic, randomised controlled trial. Lancet. 2019; 394(10195):314-321.

Government Agency, Medical Society, and Other Authoritative Publications:

1. American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS). Clinical Consensus Statement: septoplasty with or without inferior turbinate reduction. Otolaryngol Head Neck Surg. 2015; 153(5):708-720.
2. American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS). Clinical Practice Guideline: Nosebleed (Epistaxis). 2020; 162(1S):S1-S38. Available at: https://journals.sagepub.com/doi/pdf/10.1177/0194599819890327. Accessed on November 22, 2021.
3. Cummings CW, Flint P, Haughey B, et al. Otolaryngology: Head & Neck Surgery, 4th ed. Philadelphia: Mosby. 2005.

Websites for Additional Information

1. American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS). Fact sheet: deviated septum. Available at: https://www.enthealth.org/conditions/deviated-septum/. Accessed on November 22, 2021.
2. Centers for Disease Control and Prevention. Chronic Sinusitis. September 13, 2021. Available at: https://www.cdc.gov/nchs/fastats/sinuses.htm. Accessed on November 22, 2021.

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Nasal Obstruction
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History

Status	Date	Action
Reviewed	02/17/2022	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Discussion/General Information and References sections.
Revised	02/11/2021	MPTAC review. Administrative edits to Clinical Indications. Updated Discussion/General Information and References sections. Reformatted Coding section.
Reviewed	02/20/2020	MPTAC review. Added Definitions section. Updated Discussion/General Information and References sections.
Reviewed	3/21/2019	MPTAC review. Updated References section.
Reviewed	05/03/2018	MPTAC review. The document header wording updated from "Current Effective Date" to "Publish Date." Updated Websites section.
Reviewed	05/04/2017	MPTAC review.
Reviewed	05/05/2016	MPTAC review. Updated Description/Scope, Background/Overview, and References sections. Removed ICD-9 codes from Coding section.
Reviewed	05/07/2015	MPTAC review.

Reviewed	05/15/2014	MPTAC review. Updated Description and Coding sections.
Reviewed	08/08/2013	MPTAC review. Updated References.
Revised	08/09/2012	MPTAC review. Updated Discussion/General Information and References. Clarification to Clinical Indications.
Reviewed	11/17/2011	MPTAC review. Updated Discussion/General Information and References.
Reviewed	11/18/2010	MPTAC review. Updated References.
Reviewed	02/25/2010	MPTAC review. Updated References.
Reviewed	02/26/2009	MPTAC review. Updated References and Web Sites. Removed Place of Service.
Reviewed	02/21/2008	MPTAC review. References and Coding updated.
Reviewed	03/08/2007	MPTAC review. References and Coding updated.
New	03/23/2006	MPTAC initial document development.