Clinical Policy: Rhinoplasty and Septoplasty

Reference Number: WNC.CP.189 Coding Implications
Last Review Date: Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

- Rhinoplasty, septoplasty, and septorhinoplasty are surgical procedures that may be performed to correct deviation or for cosmetic or reconstructive purposes..

Related Clinical Coverage Policies

- Refer to WellCare North Carolina Clinical Coverage Guidelines for the related coverage policy listed below:
  - WNC.CP.236 Reconstructive and Cosmetic Surgery
  - WNC.CP.237 Craniofacial Surgery

Definitions

- **Rhinoplasty**
  This is a cosmetic or reconstructive surgery done to alter the contours of the nose without the involvement of the underlying nasal septa. It can correct impaired breathing caused by structural defects in the nose.

- **Septoplasty**
  Involves only the septum, the procedure is used to correct deformities of the nasal septum.

- **Septorhinoplasty**
  A more extensive procedure combining repairs to the external nasal pyramid or skeleton with repairs of the nasal septa to correct a functional impairment involving both structures. This may involve correcting damage or functional deficits that result from disease, surgery, or trauma. Surgery may also be performed to correct a congenital defect.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover rhinoplasty and septoplasty procedures when the member meets the following criteria:

A. Rhinoplasty

1. WellCare of North Carolina® shall cover rhinoplasty procedures when **any** of the following criteria are met:
   a. Nasal deformity secondary to a congenital cleft lip, palate or another congenital craniofacial deformity causing a functional impairment.

b. Reconstruction following removal of a nasal malignancy, an abscess, or osteomyelitis that has caused severe deformity and breathing difficulty.
c. Deformity caused by documented trauma within the previous 18 months.

B. Septoplasty

1. WellCare of North Carolina® shall cover septoplasty procedures when **any** of the following criteria are met:
   a. Septal deviation that causes continuous nasal airway obstruction, resulting in nasal breathing difficulty that does not respond to appropriate medical therapy.
   b. Four or more documented episodes of recurrent sinusitis in the last 365 days with exacerbations secondary to a deviated septum that do not resolve after appropriate medical and antibiotic therapy.
   c. Four or more documented episodes of recurrent epistaxis with exacerbations related to a septal deformity.
   d. Septoplasty performed in association with a cleft lip or a cleft palate repair.
   e. Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures.
   f. Deformities of the bony nasal pyramid that directly cause symptomatic airway compromise, sleep apnea, or chronic rhinosinusitis when these conditions are not responsive to appropriate medical management.

II. WellCare of North Carolina® shall not cover Rhinoplasty and Septoplasty procedures when they are performed:

A. To improve appearance; **or**
B. More than 18 months after the documented trauma that caused the deformity.

Coding Implications[1]

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

CPT®* Codes	Description
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30580	Repair fistula; oromaxillary
30600	Repair fistula; oronasal
30620	Septal or other intranasal dermatoplasty
30630	Repair nasal septal perforations

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	06/21
Reviewed CPT codes.	03/22	05/22
Annual Review.	02/23	02/23
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual Review. Removed ICD-10-CM code table.	02/24	02/24
Annual Review. Removed "/or" from the title of the policy. Description changed to "~~R~~Rhinoplasty, septoplasty, and septorhinoplasty are surgical procedures that may be performed for cosmetic or reconstructive purposes." Added "Related Clinical Coverage Policies." Added Definitions. Criteria I. changed to "WellCare of North Carolina® shall cover rhinoplasty and septoplasty procedures when the member meets the following criteria." Deleted Criteria I.A.-H. and replaced with Criteria I.A. and B. as new criteria for Rhinoplasty and Septoplasty. Criteria II. Changed verbiage to "WellCare of North Carolina® shall not cover Rhinoplasty and Septoplasty procedures when they are performed:" Criteria II.A. Removed language that listed non-inclusive items. Criteria II.B. Removed the word "significant." Deleted	02/25	02/25

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Background verbiage. CPT codes reviewed. Removed "Medicaid and health choice" verbiage from References.		
Under Description added "to correct deviation or." Criteria I.B.1.b. Added criteria that "recurrent sinusitis" is four or more episodes in the last 365 days "with exacerbations." Criteria I.B.1.c. added 'recurrent' epistaxis with 'exacerbations." Under NC Guidance/Claims related information, updated state web address.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1O-5 Rhinoplasty and/or Septoplasty. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2025. Accessed April 4, 2025.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
g. https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices
   Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional

organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.