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1.0 Description of the Procedure, Product, or Service

The terms rhinoplasty, septoplasty, and septorhinoplasty are sometimes used interchangeably, but they have distinct meanings. A *rhinoplasty* is cosmetic or reconstructive surgery done to alter the contours of the nose itself without involvement of the underlying nasal septa. A *septoplasty*, on the other hand, involves only the septum. However, in clinical practice, a surgical procedure sometimes involves elements of both a rhinoplasty and a septoplasty. This is referred to as a *septorhinoplasty*, a more extensive procedure combining repairs to the external nasal pyramid or skeleton with repairs of the nasal septa in order to correct a functional impairment involving both structures. This may involve correcting damage or functional deficits that result from disease, surgery, or trauma. The surgery may also be performed to correct a congenital defect such as a cleft lip or palate.

2.0 Eligible Recipients

2.1 General Provisions

NC Medicaid (Medicaid) recipients must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) recipients, ages 6 through 18 years of age, must be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

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

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 recipient'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**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid and NC Health Choice Billing Guide:

<http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.3 Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Recipients ages 6 through 18 years of age

EPSDT does not apply to NCHC recipients. If a NCHC recipient does not meet the clinical coverage criteria within **Section 3.0** of the clinical coverage policy, the NCHC recipient will be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes will be covered for NCHC recipients.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

3.1 General Criteria

Procedures, products, and services related to this policy are covered when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid and NCHC rhinoplasty/septoplasty procedures are covered when **any** of the following criteria are met:

- a. Septal deviation causing continuous nasal airway obstruction, resulting in nasal breathing difficulty that does not respond to appropriate medical therapy.
- b. Deformities of the bony nasal pyramid that directly cause significant and symptomatic airway compromise, sleep apnea, or recurrent or chronic rhinosinusitis when these conditions are not responsive to appropriate medical management.
- c. Documented recurrent sinusitis felt to be due to a deviated septum and not relieved by appropriate medical and antibiotic therapy.
- d. Recurrent epistaxis related to a septal deformity.
- e. Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures.
- f. Deformity secondary to congenital cleft lip and/or palate or other congenital defect of the nose.
- g. Reconstruction following removal of a nasal malignancy, an abscess, or osteomyelitis that has caused severe deformity and breathing difficulty.
- h. Significant deformity caused by specifically documented trauma within the previous 18 months.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Non-Covered Criteria

Rhinoplasty/septoplasty procedures are not covered when they are performed:

- a. to improve appearance, instead of primarily to restore bodily function or to correct a significant deformity caused by congenital anomaly, injury, disease, or growth and development that resulted in significant functional impairment or disfigurement; or
- b. more than 18 months after the documented trauma that caused the significant deformity.

4.3 NCHC Non-Covered Criteria

Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Health Choice program shall be equivalent to coverage provided for dependents under the NC Medicaid Program except for the following:

- a. no services for long-term care;
- b. no non-emergency medical transportation;
- c. **no EPSDT**; and
- d. dental services shall be provided on a restricted basis.

4.4 Medicaid Non-Covered Criteria

No additional non-covered criteria.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

5.1 Prior Approval

Prior approval is required for most rhinoplasty procedures for Medicaid and NCHC recipients. See **Attachment A, Letter C** for a list of procedures that require prior approval.

5.2 Prior Approval Requirements

The provider(s) shall submit to DMA's designee the following:

- a. the prior approval request; and
- b. all health care records and any other records that support the recipient has met the specific criteria in **Subsection 3.2** of this policy including:
 1. Location and cause of the defect/deformity.
 2. Pre-operative medical photographs of the defect consisting of frontal, lateral, and columellar reviews.
 3. Listing of the CPT codes describing the procedure to be performed.
 4. Documentation of frequency, severity, and description of symptoms.
 5. Bodily function that will be improved or restored.
 6. Medical records documenting the history of the trauma or injury (if applicable), with the date of injury and any other related surgeries.
 7. Documentation of sleep apnea and/or symptoms of breathing obstruction, if applicable, including consecutive treatment rendered; and
- c. if the Medicaid recipient is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; 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.

7.0 Additional Requirements

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1985

Revision Information:

Date	Section Revised	Change
7/1/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
3/1/2012	Throughout	To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 1-O-5 under Session Law 2011-145 § 10.41.(b)
3/1/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid or NCHC guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid and NCHC managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Billing Code(s)

The following procedure codes require prior approval.

CPT Code	Description
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
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)

The following procedure codes do not require prior approval:

CPT Code	Description
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
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 (eg, 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 (combine with 31030 if antrotomy is included)
30600	Repair fistula; oronasal
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	Repair nasal septal perforations

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient hospital, Outpatient hospital, Ambulatory surgery center, office, clinic.

G. Co-payments

Recipients do not pay co-payments for rhinoplasty procedures.

H. Reimbursement

Providers are required to bill applicable revenue codes.

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>