



Guidelines for Medical Necessity Determination for Rhinoplasty and Septoplasty

This edition of the *Guidelines for Medical Necessity Determination* (Guidelines) identifies the clinical information that MassHealth needs to determine medical necessity for rhinoplasty and septoplasty. These Guidelines are based on generally accepted standards of practice, review of the medical literature, and federal and state policies and laws applicable to Medicaid programs.

Providers should consult MassHealth regulations at [130 CMR 415.000](#): *Acute Inpatient Hospital Services*; [130 CMR 433.000](#): *Physician Services*; [130 CMR 410.000](#): *Outpatient Hospital Services*; [130 CMR 450.000](#): *Administrative and Billing Regulations*; [Subchapter 6](#) of the *Acute Outpatient Hospital Manual*, and [Subchapter 6](#) of the *Physician Manual* for information about coverage, limitations, service conditions, and other prior-authorization (PA) requirements.

Providers serving members enrolled in a MassHealth-contracted accountable care partnership plan (ACPP), managed care organization (MCO), One Care organization, Senior Care Options (SCO) plan, or a Program of All-inclusive Care for the Elderly (PACE) should refer to the ACPP's, MCO's, One Care organization's, SCO's, or PACE's medical policies, respectively, for covered services.

MassHealth requires PA for rhinoplasty and septoplasty. MassHealth reviews requests for PA based on medical necessity. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, and program restrictions.

SECTION I. GENERAL INFORMATION

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Reconstructive rhinoplasty is surgery of the nose to correct an external nasal deformity or damaged nasal structures, or to replace lost tissue, while maintaining or improving the physiological function of the nose.

Reconstructive septoplasty is the 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.

Nasal septoplasty corrects anatomic deformity or deviation of the nasal septum. The procedure restores the structure facilitating proper nasal function. Any cosmetic enhancement is incidental. Because the septum is deviated in most adults, there is a potential for over-utilization of septoplasty in asymptomatic individuals. The primary indication for surgical treatment of a deviated septum is nasal airway obstruction. Corrective surgery also is done to treat recurrent epistaxis associated with the septal deviation or sinusitis in which the deviation has a contributory role; and, occasionally, is necessary to gain access to another region, such as the sphenoid, sella turcica, or pituitary gland. In addition, septoplasty may be performed in response to an injury (nasal trauma) or in conjunction with cleft palate repair.

Cosmetic rhinoplasty and/or septoplasty performed solely to enhance appearance are not covered by MassHealth.

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SECTION II. CLINICAL GUIDELINES

- I. MassHealth considers septoplasty medically necessary when *any* of the following clinical criteria are met:
- A. Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g., ethmoidectomy); or
 - B. Documented recurrent sinusitis (i.e., a minimum of three episodes over a 12-month period), thought to be due to a deviated septum not relieved by appropriate medical and antibiotic therapy; or
 - C. Nasal septum trauma resulting in significant functional deformity that was not present before the injury; or
 - D. Need for reconstruction after the removal of a tumor, nasal polyps, or surgical removal of part of the ethmoid bone; or
 - E. Patient has obstructive sleep apnea and is having difficulty tolerating continuous positive airway pressure (CPAP), due to significant nasal obstruction that is unresponsive to conservative management, and septoplasty is being performed to enhance CPAP or bilevel positive airway pressure (BiPAP) effectiveness; or
 - F. Recurrent epistaxis (nosebleeds) thought to be related to an underlying septal deformity; or
 - G. Septal deviation that causes continuous nasal airway obstruction resulting in difficulty breathing from the nasal passages despite four or more weeks of appropriate medical therapy; or
 - H. When done in association with cleft lip or palate repair.

MassHealth considers septoplasty experimental and investigational for all other indications (e.g., allergic rhinitis), due to a lack of authoritative evidence to establish its clinical efficacy at this time.

- II. MassHealth considers extracorporeal septoplasty medically necessary for initial correction of an extremely deviated nasal septum that cannot be adequately corrected with an intranasal approach, for members who meet criteria for septoplasty listed in the clinical guidelines.

MassHealth considers extracorporeal septoplasty for revision of deviated septum experimental and investigational, due to a lack of authoritative evidence to establish its clinical efficacy at this time.

- III. Rhinoplasty may be considered medically necessary in the following limited circumstances:

- A. When it is being performed to correct a nasal deformity secondary to congenital cleft lip and/or palate or for removal of a nasal dermoid (photographic evidence of the anatomical abnormality must be provided); or
- B. Upon individual case review, to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to congenital defect, trauma, or disease, when *all* of the following criteria are met:
 - 1. Airway obstruction that will not respond to turbinectomy and septoplasty alone; and
 - 2. Functional impairment that is expected to be resolved by rhinoplasty; and

3. Nasal airway obstruction that is causing significant symptoms (e.g., difficulty breathing, chronic rhinosinusitis); and
4. Obstructive symptoms that persist despite conservative management for at least four weeks or more, including nasal steroids or immunotherapy, when appropriate; and
5. Persistent and prolonged obstructed nasal breathing; and
6. Photographs that demonstrate an external nasal deformity; and
7. Physical examination that confirms moderate to severe vestibular obstruction; and
8. Significant obstruction of one or both nares, documented by CT scan, nasal endoscopy, or other appropriate imaging modality; and

or

- C. When rhinoplasty for nasal airway obstruction is performed as a component of medically necessary septoplasty and there is documentation of gross nasal obstruction on the same side as the septal deviation; or
- D. There is severe deformity and difficulty breathing related to an underlying inflammatory disease (e.g., pleomorphic granulomatosis, granulomatosis with polyangiitis), abscess, or osteomyelitis; or following the removal of nasal malignancy that has caused difficulty breathing and severe deformity.

*Criteria B and C must include documentation detailing:

1. The duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.; and
2. The response to conservative management of symptoms; and
3. If there is an external nasal deformity, pre-operative photographs showing the standard four-way view: anterior-posterior, right and left lateral views, and base of nose (also known as worm's-eye view, confirming vestibular stenosis; this view is from the bottom of nasal septum pointing upwards); and
4. Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity); and
5. Results of nasal endoscopy, CT, or other appropriate imaging modality documenting degree of nasal obstruction.

MassHealth considers all other indications for rhinoplasty experimental and investigational, due to a lack of authoritative evidence to establish their clinical efficacy — e.g., repair of nasal valve collapse; use of absorbable nasal implant (e.g., the Spirox Latera Absorbable Nasal Implant); concentrated growth factor extracted from blood plasma for repair of nasal septal mucosal defect following rhinoplasty; septal swell bodies for the treatment of chronic rhinitis; chronic sinusitis; or nasal pyriform aperture reduction (pyriform turbinoplasty) for the treatment of nasal obstruction.

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SECTION III: SUBMITTING CLINICAL DOCUMENTATION

A. PRIOR AUTHORIZATION

Requests for PA must be submitted by the MassHealth-enrolled surgeon performing the procedure and accompanied by clinical documentation that supports the medical necessity for the procedure, including, but not limited to, the assessment made by the qualified licensed health professional(s) and the referral(s) for surgery from the qualified licensed health professional(s). Documentation of medical necessity must include all the following.

I. **History** – One or more of the following is required.

- A. Asymptomatic deformity that prevents surgical access to other intranasal areas (i.e., ethmoidectomy);
- B. Atypical facial pain of nasal origin. Positive response to topical anesthetic, where deformed septum contacts a turbinate, supports but may not prove septal cause;
- C. Frequent nosebleeds; or
- D. Nasal airway obstruction or difficult nasal breathing causing any of the following: mouth breathing, snoring, sleep apnea, or recurrent sinus infections.

II. **Physical Examination** – When appropriate, all of the following findings are required.

- A. Description of complete anterior and posterior nasal examination;
- B. Description of nasopharynx, oropharynx, hypopharynx, and larynx if purpose of surgery is to prevent sleep apnea or snoring;
- C. Documented absence of nasal polyps, tumors, turbinate hypertrophy, or other causes of obstruction, unless their removal is part of the proposed surgery;
- D. Identification of known or suspected bleeding site if the purpose of surgery is to control epistaxis;
- E. Identification of sinus that is recurrently infected if the purpose of surgery is to control disease.

The American Academy of Otolaryngology-Head and Neck Surgery (AAOHNs) states that objective testing (e.g., CT scan) is optional in assessing the need for septoplasty.

B. SUBMITTING DOCUMENTATION

As previously noted, all clinical information must be submitted by the surgeon performing the surgery.

Providers must electronically submit PA requests and all supporting documentation using the Provider Online Service Center (POSC), unless the provider has a currently approved electronic claims waiver (hereinafter, “waiver”). Please see [All Provider Bulletin 369](#) for further waiver information. Questions about POSC access should be directed to the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711.

For PA requests that are not submitted using the POSC, providers with currently approved waivers must include the MassHealth Prior Authorization Request (PA-1 Form) and all supporting documentation. The PA-1 Form can be found at [mass.gov/how-to/request-prior-authorization-for-nonpharmacy-services](https://www.mass.gov/how-to/request-prior-authorization-for-nonpharmacy-services).

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SECTION IV: REFERENCES

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These Guidelines are based on review of the medical literature and current practice in the treatment of for rhinoplasty and septoplasty. MassHealth reserves the right to review and update the contents of these Guidelines and cited references as new clinical evidence and medical technology emerge.

This document was prepared for medical professionals to assist them in submitting documentation supporting the medical necessity of the proposed treatment, products, or services. Some language used in this communication may be unfamiliar to other readers; such readers are encouraged to contact their healthcare provider for guidance or explanation.

Policy Revision Effective Date: January 17, 2025

Approved by:

A handwritten signature in black ink, appearing to read 'Clara Filice', written over a horizontal line.

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