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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.

### 1.1 Definitions

None Apply.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
None Apply.

## 2.2 Special Provisions

### 2.2.1 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.

#### b. EPSDT and Prior Approval Requirements

- a. 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.
- b. **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: <http://dma.ncdhhs.gov/>

### **2.2.2 EPSDT does not apply to NCHC beneficiaries**

### **2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

## **3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when 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 beneficiary'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 beneficiary, the beneficiary's caretaker, or the provider.

### **3.2 Specific Criteria Covered**

#### **3.2.1 Specific criteria covered by both Medicaid and NCHC**

Medicaid and NCHC shall cover rhinoplasty/septoplasty procedures 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.

### **3.2.2 Medicaid Additional Criteria Covered**

None Apply.

### **3.2.3 NCHC Additional Criteria Covered**

None Apply.

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

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service 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 Criteria Not Covered**

#### **4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

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.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent

to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

## 5.0 Requirements for and Limitations on Coverage

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

### 5.1 Prior Approval

Prior approval is required for most rhinoplasty procedures for Medicaid and NCHC beneficiaries. 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 beneficiary has met the specific criteria in **Subsection 3.2.1** 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. Medical photographs should be clearly marked with:
    - A. the beneficiary’s first and last name;
    - B. the beneficiary’s identification number;
    - C. the provider’s name and NPI;
    - D. and the date the photographs were taken.
  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 beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

#### 5.2.1 Specific

None Apply.

### 5.3 Additional Limitations or Requirements

None Apply.

## **6.0 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 or NCHC 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.

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

None Apply.

### **6.2 Provider Certifications**

None Apply.

## **7.0 Additional Requirements**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **7.1 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 DMA'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).

## 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, <b>Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”</b>
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.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
04/01/2018	Subsection 5.2.b.2	Additional clarification for the photographs was added.

### Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

**B. International Classification of Diseases, 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.

CPT Code(s)	
The following procedure codes require prior approval.	
30400	30430
30410	30435
30420	30450

CPT Code(s)	
The following procedure codes do not require prior approval.	
21235	30545
30460	30560
30462	30580
30465	30600
30520	30620
30540	30630

**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**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Provider(s) shall report the appropriate code(s) used which determines the billing unit unit(s).

**F. Place of Service**

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

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://dma.ncdhhs.gov/>.

For NCHC refer to [G.S. 108A-70.21\(d\)](#).

**H. Reimbursement**

Providers are required to bill applicable revenue codes.

Providers shall bill their usual and customary charges.

For a schedule of rates, refer to: <http://dma.ncdhhs.gov/>