# Rhinoplasty and Other Nasal Procedures

**Policy Number**: SRSTMP.019.35
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➲ Instructions for Use

**Table of Contents** **Page**



**Related Policies**

None

## Coverage Rationale

➲ See Benefit Considerations

**Nasal valve procedures/repair of nasal vestibular stenosis or alar collapse are considered reconstructive and medically necessary when all the following criteria are present:**

- Prolonged, Persistent, Obstructed nasal breathing due to internal and/or External Nasal Valve compromise; and
- Other causes of nasal obstruction (e.g., rhinosinusitis, allergic rhinitis, vasomotor rhinitis, nasal polyposis, adenoid hypertrophy, and/or nasopharyngeal masses) have been adequately treated with maximal therapy and nasal obstruction persists; and
- Nasal septal deviation and turbinate hypertrophy either:
  - Are not present; or
  - Have been previously surgically treated; or
  - Are scheduled to be surgically treated at the same time as the nasal valve procedure/repair as part of the surgery plan

  and
- Documented evidence of visible collapse of the alar (lower lateral) cartilage (External Nasal Valve) and/or lateral nasal wall (internal nasal valve) with deep inspiration; and
- Documented evidence of subjective and audible improvement in nasal airflow during modified Cottle maneuver; and
- Photos clearly document either dynamic collapse of the internal and/or External Nasal Valve or anatomical deformities narrowing the internal and/or External Nasal Valve as a main cause of an anatomical Mechanical Nasal Airway Obstruction and are consistent with the clinical examination; and
- The surgeon has clearly described:
  - Whether the nasal valve compromise is static or dynamic; and
  - Whether the nasal valve compromise involves the internal nasal valve, External Nasal Valve, or both; and
  - A plainly stated and clear surgical plan, including the need for a cartilage graft

**Nasal valve procedures/repair of nasal vestibular stenosis or alar collapse are not considered reconstructive and medically necessary in all other indications.**

**Rhinoplasty for congenital anomalies is considered reconstructive and medically necessary when the rhinoplasty is performed for a nasal deformity associated with congenital craniofacial anomalies, including but not limited to Pierre Robin syndrome, Apert syndrome, Fraser syndrome, Binder syndrome, Goldenhar**

**syndrome, nasal dermoids, and Tessier nasal cleft (most commonly number 1), or associated with a cleft lip or cleft palate.**

**Rhinoplasty for congenital anomalies is not considered reconstructive and medically necessary in all other indications.**

**Rhinoplasty – primary is considered reconstructive and medically necessary when all the following criteria are present:**

- The indication for surgery is **one** of the following:
  - Prolonged, Persistent, Obstructed nasal breathing due to nasal bone and septal deviation that are the primary causes of an anatomical Mechanical Nasal Airway Obstruction; or
  - Nasal fracture with nasal bone displacement that is severe enough to cause nasal airway obstruction; or
  - Residual large cutaneous defect following resection of a malignancy or nasal trauma

  and
- The nasal airway obstruction cannot be corrected by septoplasty alone, as documented in the medical record; and
- Photos clearly document the nasal bone/septal deviation as the primary cause of an anatomical Mechanical Nasal Airway Obstruction and are consistent with the clinical examination; and
- The proposed procedure is designed to correct the anatomical Mechanical Nasal Airway Obstruction and relieve the nasal airway obstruction by centralizing the nasal bony pyramid and straightening the septum; and
- Nasal airway obstruction is causing significant symptoms (e.g., Chronic Rhinosinusitis, difficulty breathing); and
- Obstructive symptoms persist despite conservative management for 4 weeks or greater, which includes, where appropriate, nasal steroids or immunotherapy

**Rhinoplasty – primary is not considered reconstructive and medically necessary in all other indications.**

**Rhinoplasty – revision is primarily cosmetic. However, it is considered reconstructive and medically necessary when all the following criteria are present:**

- Required as treatment of a complication/residual deformity from primary surgery performed to address a Functional Impairment when a documented Functional Impairment persists due to the complication/deformity (these codes are usually cosmetic); and
- Photos clearly document the secondary deformity/complication as the primary cause of an anatomical Mechanical Nasal Airway Obstruction and are consistent with the clinical examination; and
- The proposed procedure is designed to correct the anatomical Mechanical Nasal Airway Obstruction and relieve the nasal airway obstruction by correcting the deformity or treating the complication (these codes are usually cosmetic); and
- Nasal airway obstruction is causing significant symptoms (e.g., Chronic Rhinosinusitis, difficulty breathing); and
- Obstructive symptoms persist despite conservative management for 4 weeks or greater, which includes, where appropriate, nasal steroids or immunotherapy

**Rhinoplasty – revision is not considered reconstructive and medically necessary in all other indications.**

**Rhinoplasty – tip is primarily cosmetic. However, it is considered reconstructive and medically necessary when all the following criteria are present:**

- Prolonged, Persistent, Obstructed nasal breathing due to tip drop that is the primary cause of an anatomical Mechanical Nasal Airway Obstruction (this code is usually cosmetic); and
- Photos clearly document tip drop as the primary cause of an anatomical Mechanical Nasal Airway Obstruction and are consistent with the clinical examination (acute columellar-labial angle); and
- The proposed procedure is designed to correct the anatomical Mechanical Nasal Airway Obstruction and relieve the nasal airway obstruction by lifting the nasal tip; and
- Nasal airway obstruction is causing significant symptoms (e.g., Chronic Rhinosinusitis, difficulty breathing); and
- Obstructive symptoms persist despite conservative management for 4 weeks or greater, which includes, where appropriate, nasal steroids or immunotherapy

**Rhinoplasty – tip is not considered reconstructive and medically necessary in all other indications.**

**Nasal polypectomy is considered reconstructive and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Polypectomy, Nasal.

Click here to view the InterQual® criteria.

**Nasal polypectomy is not considered reconstructive and medically necessary in all other indications.**

# Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

**Acute Rhinosinusitis**: Acute Rhinosinusitis is a clinical condition characterized by inflammation of the mucosa of the nose and paranasal sinuses with associated sudden onset of symptoms of purulent nasal drainage accompanied by nasal obstruction, facial pain/pressure/fullness, or both of up to 4 weeks' duration. (Rosenfeld et al., 2015)

**Chronic Rhinosinusitis**: Chronic Rhinosinusitis is one of the more prevalent chronic illnesses in the United States and is an inflammatory process that involves the paranasal sinuses and persists for longer than 12 weeks. (Rosenfeld et al., 2015)

**External Nasal Valve**: The External Nasal Valve includes the caudal edge of the lateral crus of the lower lateral cartilage, soft tissue alae, membranous septum, and sill of the nostril. It is the entrance to the nose. (Totonchi et al. 2024)

**Functional or Physical or Physiological Impairment**: A Functional or Physical or Physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; and performing basic life functions. (Medicare, 2023)

**Mechanical Nasal Airway Obstruction**: Trouble breathing through the nose (not snoring) due to a bony or cartilaginous deformity. (Corey and Most, 2009)

**Prolonged, Persistent Nasal Airway Obstruction**: Trouble breathing through the nose (not snoring) that has not responded to 6 weeks of medical management such as nasal steroids, antihistamines, and decongestants. Elimination of drug-induced rhinitis, including Rhinitis Medicamentosa, as a cause for airway obstruction. (Corey and Most, 2009)

**Recurrent Acute Rhinosinusitis**: Recurrent Acute Rhinosinusitis has been defined as four episodes per year of Acute Rhinosinusitis, with distinct symptom-free intervals between episodes. (Rosenfeld et al., 2015)

**Rhinitis Medicamentosa**: A condition of rebound nasal congestion brought on by extended use of topical decongestants (e.g., oxymetazoline, phenylephrine, xylometazoline, naphazoline nasal sprays) that constrict blood vessels in the lining of the nose. It classifies as a subset of drug-induced rhinitis. (Wahid and Shermetaro, 2022)

# Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| 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) |
| 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 |

| CPT Code | Description |
|---|---|
| 30465 | Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction) |
| 30468 | Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s) |
| 30469 | Repair of nasal valve collapse with low energy, temperature-controlled (i.e., radiofrequency) subcutaneous/submucosal remodeling |
| 31237 | Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure) |
| 31242 | Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve |
| 31243 | Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve |



# Description of Services

**Nasal valve procedures/repair of nasal vestibular stenosis or alar collapse**: Surgical procedures to correct nasal valve or vestibule impairment caused by aging, congenital anomaly, or prior nasal surgery to restore the nasal airway.

**Rhinoplasty**: A surgical procedure of the nose for reconstructive reasons to improve a nasal deformity or a damaged nasal structure or to replace lost tissue, while maintaining or improving the physiological function of the nose. It can also be done for cosmetic purposes to correct or improve the external appearance of the nose.

**Rhinoplasty for congenital anomalies**: A rhinoplasty procedure to address a medical condition present at or from birth that significantly deviates from the common structure or function of the nose or nasal airway; these procedures are most commonly done to treat cleft lip and palate abnormalities or for removal of a nasal dermoid.

**Rhinoplasty – primary**: The first rhinoplasty operation performed on a nose.

**Rhinoplasty – revision**: Any subsequent or revision rhinoplasty surgeries performed on a nose.

**Rhinoplasty – tip**: A surgical procedure of the tip of the nose to improve nasal function by repairing an existing defect or to enhance the appearance.

**Nasal polypectomy**: A surgical procedure to remove polyps located in the nasal passages.

# Benefit Considerations

Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Refer to the member specific benefit plan document.

# Clinical Evidence

## Nasal Valve Procedures/Repair of Nasal Vestibular Stenosis or Alar Collapse

Marianetti et al. (2024) conducted a prospective, single-center, single-arm study to evaluate the efficacy of the alar extension graft for the correction of external nasal valve collapse and to evaluate the functional and aesthetic results. The study included 51 adults (23.5% male; mean age, 35.4 years) with external nasal valve collapse as the sole factor of nasal obstruction and who underwent open rhinoplasty. Rhinomanometry was performed before and after surgery, along with the completion of the Nasal Obstruction Symptom Evaluation (NOSE) and Sino-Nasal Outcome Test-20 (SNOT- 20) questionnaires at baseline and at 9 months after surgery. The authors reported that 90% of the participants were subjectively satisfied with the postoperative improvement in nasal breathing and that there was significant improvement in the values of the preoperative (62 points) and postoperative (29 points) NOSE scores and SNOT- 20 questionnaire scores (28 points prior to the operation and 18 points post operation). The authors also reported that rhinomanometry showed increased nasal flow, with a statistically significant difference between preoperative (515.53 ml/s) and postoperative (588.61 ml/s) results. Limitations of the study include the small study population size, single-center design, lack of a control group, and short-term follow-up. The authors concluded that the alar extension graft was proven to be effective and reliable in the surgical treatment of external nasal valve collapse, with improvement in objective and subjective breathing and good functional and aesthetic results.

In a single-center retrospective study on the efficacy of septal extension graft (SEG) use in the treatment of alar collapse, Resuli et al. (2023) reported that the SEG technique, which they applied for nasal projection in rhinoplasty surgery, increased the extension of the lower lateral cartilage lateral ridge and alar structures. The study included 23 patients, 18 male and five female, with mean ages of 45.5 and 39.7 years, respectively, with alar collapse, a positive Cottle test, and bilateral dynamic nasal collapse. Other causes of nasal obstruction (such as septal deviation, allergic rhinitis, turbinate hypertrophy, acute and/or chronic sinusitis, and nasal polyp) were not found in any of the patients, and facial nerve examinations were normal. The authors reported that there were no reports of nasal obstruction on deep inspiration noted by the patients at their 6-month postoperative follow-up. The mean respiratory score was 152 post operation, compared with 66.5 prior to the operation. The authors concluded that SEG use is effective for individuals with bilateral nasal collapse and thick-short columella that results in a significant increase in nasal vestibular volume.

Goudakos et al. (2016) performed a systematic review to assess knowledge and evidence of management options for the treatment of nasal valve collapse. Overall, 53 studies were identified and systematically reviewed. The majority (50 of 53) of the included articles were graded as level IV evidence, and only one randomized trial was identified. The included randomized study reported no difference in improvement between the intervention group (autospreader flap) and placebo arms. Most of the included studies presented in this systematic review provided level IV evidence concerning the optimal approach for cases of nasal valve collapse. At the time of the review, research was driven by reports of techniques rather than individuals' outcomes. The authors concluded that proper evaluation and identification of the cause of internal valve collapse are paramount prior to selection of the preferred surgical solution. Treatment approaches should be directed at specific involved sites in the internal valve and need to be tailored toward the individual's specific problem. This systematic review of the literature revealed that the available evidence is based on low-level studies and focuses more on the description of various surgical techniques rather than on patient-reported outcome measures, the latter of which is recommended in future studies. Further research, with randomized controlled trials (RCTs), is needed to validate these findings.

A systematic review was completed by Spielmann et al. (2009) to evaluate surgical treatment strategies for nasal valve collapse. The review included 43 articles from 1970 to 2008, with at least 10 individuals in each study, a stated aim to improve airway obstruction, and a minimum of a 1-month follow-up for every individual. Of these studies, one trial presented level IIIb evidence, and all other studies were classed as level IV. Seven authors presented objective measurements of nasal airflow or cross-sectional area, and four authors presented validated outcome measures. The authors concluded that there is a variety of focused surgical techniques described that deal with nasal valve collapse. They could find no RCTs on nasal valve surgery. Research in nasal valve surgery is frequently driven by a technical description of surgical technique rather than the establishment of evidence of long-term benefit in individuals. Although the understanding of the role of the nasal valve in the pathophysiology of nasal obstruction has improved vastly, the myriads of surgical techniques described reflect the uncertainty in choice of technique and in degree of benefit in individuals. Well-designed, adequately powered, prospective, RCTs of a single surgical technique are needed to further describe safety and clinical outcomes.

## *Clinical Practice Guidelines*

### American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)

In their 2023 position statement on nasal valve repair, the AAO-HNS recognizes surgical repair of the nasal valve as a distinct surgical procedure that can improve nasal obstruction symptoms for appropriately selected patients with nasal valve collapse. The AAO-HNS statement indicates that surgical approaches for the treatment of nasal valve dysfunction (NVD) may include cartilage grafting and open surgical repair, suture suspension techniques, and implants or radiofrequency treatment aimed at stabilizing the nasal valve. It also states that surgical treatment of nasal valve collapse, along with treatment of other possible causes of nasal airway obstruction (NAO), is required to optimize patient outcomes in patients who require anatomical widening and definitive stabilization of the nasal valve.

## Rhinoplasty

The systematic review and meta-analysis by Alanazi et al. (2025) evaluated 65 studies (41 with analyzable data) on the effectiveness, outcomes, and safety of primary rhinoplasty performed during cleft lip repair, and found that the combined procedure significantly improved surgical success compared with cleft repair alone (risk ratio, 1.87; $p < 0.0001$) and achieved overall goals in 73.6% of unilateral and 88% of bilateral cases, with only 14% of unilateral individuals requiring later revision. Anthropometric outcomes showed minimal differences from controls in unilateral cases but substantial differences in bilateral cases, including wider nasal width, reduced tip projection, and larger nasolabial angles—while long-term follow-up confirmed stable nasal symmetry and low complication rates. Limitations include the high heterogeneity across studies due to wide variations in deformity severity, surgical techniques, and outcome measurement methods; inconsistent follow-up durations; and limited data for bilateral cases, restricting the strength of subgroup

conclusions. Overall, the findings support primary rhinoplasty as an effective and generally safe component of cleft lip repair and emphasize the need for standardized techniques and assessment tools in future research.

Yuan and An (2024) conducted a systematic review to evaluate the improvement in NAO after secondary rhinoplasty for cleft lip. The review included 29 studies (15 case series, seven prospective cohort, five retrospective cohort, and two case reports), with a total population of 1,031 individuals with cleft lip. Nasal ventilation outcomes were measured using subjective methods in 21 studies and with objective methods in eight studies. Comparison groups were included in six of the studies that used subjective methods and all of the studies that used objective methods to assess nasal ventilation outcomes. All of the studies included human individuals undergoing secondary rhinoplasty with cleft lip nasal deformity and were published between 2004 and 2023. The authors reported that all 29 studies consistently demonstrated that secondary rhinoplasty can effectively eliminate or alleviate symptoms of NAO, with improvement seen in the domains of snoring, trouble breathing through the nose, and the ability to get enough air through the nose during physical exertion. The authors also reported that it is generally recommended to perform definitive rhinoplasty after complete facial development, as it has a higher improvement rate and avoids potential subsequent anatomical changes in nasal structure; however, if severe nasal obstruction caused by caudal septal deviation is present or significant emotional distress due to peer psychological pressure is present, intermediate rhinoplasty can be considered as an early intervention. Limitations of the study include the heterogeneity of the study designs, measurement tools, and surgical techniques. The authors concluded that the review posits that secondary cleft lip rhinoplasty can effectively ameliorate NAO and recommended that larger-scale, comparative studies be conducted to address more specific inquiries, including surgical techniques and optimal measurement methodologies.

In a single-center retrospective cohort study in patients who underwent closed nasal reduction of nasal bone fractures, Besmens et al. (2023) determined the rate of rhinoplasty after fracture reduction and analyzed the factors affecting the outcome and need for revision rhinoplasty. The study included a record review of 417 consecutive patients (306 male and 111 female patients) with a median age of 30 years. There were 371 patients (89%) who had a closed fracture and 46 (11%) who had open fractures. One-third of all patients [n = 139 (33.3%)] had an associated nasal septum fracture, and septal deviation was visible via computed tomography or clinically present in 135 patients (32.4%); a dislocated septum was noted in 56 patients (13.4%). There were 46 patients who had sustained at least one prior nasal fracture, and these patients were more likely to require revision rhinoplasty. Closed reduction was performed an average of 6 days post trauma, with gauze removal 2 days post operation, and cast removal occurred after 7 days. The authors reported that 47 patients (11.3%) required revision rhinoplasty after fracture healing, which was performed an average of 398 days (range, 214-592 days) after the initial reduction. The authors reported that patients who experienced an additional septum fracture or septal deviation were more likely to undergo rhinoplasty and that the risk of the need for open revision rhinoplasty after fracture healing was significantly increased in patients reporting airway obstruction at the time of cast removal after closed reduction. Limitations of the study include the retrospective design, inclusion of cases operated on by multiple surgeons, lack of medical records related to possible existence of airway obstruction prior to the nasal fracture, and lack of medical records for patients lost to follow-up who may have undergone revision rhinoplasty elsewhere. The authors concluded that a significant number of patients will require secondary revision rhinoplasty, even though closed reduction of nasal fractures is frequently considered a straightforward procedure. The authors recommended prospective studies to support the findings of their investigation.

A meta-analysis by Zhao et al. (2022) was performed to evaluate the effects of functional rhinoplasty on nasal obstruction in individuals with nasal valve problems. A total of 57 cohorts from 43 studies, involving 2,024 individuals, were included in the current meta-analysis (level of evidence III). NOSE scores indicated significant improvement in nasal obstruction at the 1-month, 3-month, 6-month, 12-month, and last follow-up with respect to the preoperative baseline. Visual analog scale (VAS) scores indicated a similar trend at the 1-month, 3-month, 6-month, and last follow-up. Nasal obstruction was demonstrated as relieved through rhinomanometry but not through peak nasal inspiratory flow. The authors concluded that functional rhinoplasty may have a positive effect on nasal obstruction caused by nasal valve problems. The findings of this study need to be validated by broader, well-designed studies.

A systematic review and meta-analysis by Pfaff et al. (2021) was performed to evaluate the effects of septoplasty (SPL), septorhinoplasty (SRP), and rhinoplasty procedures on postoperative olfactory function and their relationship to nasal airflow and quality of life (QOL). Preoperative and postoperative values for olfaction, nasal airflow, and QOL/nasal symptoms were analyzed. The effect size was calculated from each study and used for meta-analysis. As studies evaluated individuals at different points in the postoperative period, the latest time point reported by each study was used in the meta-analysis. All included studies were level of evidence II. There were 25 included studies. Three studies were randomized prospective studies, seven were comparative studies, and 15 were noncomparative studies. Following nasal surgery, individuals experienced significant improvements in olfaction ($p < 0.001$), nasal airflow ($p < 0.001$), and QOL/nasal symptoms ($p < 0.001$). Individuals often experienced a transient decrease in olfaction immediately after surgery, followed by improvement post operation. Preoperative olfactory dysfunction rates were low, and postoperative

dysfunction was equally low. Olfaction improvement was directly correlated with improvement in nasal airflow and QOL. The authors concluded that functional and aesthetic nasal operations appear to improve olfaction, which is directly correlated with nasal airflow. Some studies reported a transient worsening of these measures in the immediate postoperative period, which improved at later time points. The study is limited due to a heterogeneous population of individuals. In addition, due to smaller sample sizes, there is an inherent risk of publication bias.

Martin et al. (2021) completed a prospective RCT to evaluate the subjective and objective outcome of SPL and SRP on participant satisfaction. Participants with functional indication for SPL (n = 19) or SRP (n = 54) were included and randomized for additional turbinoplasty. Preoperative clinical symptoms were collected with the SNOT-20 German Adapted Version (GAV) and NOSE questionnaires. The final evaluation of treatment success was performed 9 months after surgery with the SNOT-20 GAV, the NOSE, and a self-established feedback questionnaire. Nasal breathing and obstruction were objectively measured with rhinomanometry and acoustic rhinometry [minimum cross-sectional area 2 (MCA2)]. MCA2 was statistically improved compared with the pretreatment value in SPL ($p = 0.0004$) and SRP ($p = 0.0001$). Regarding MCA2 values of matched participant groups, similar findings were detected (SPL: $p = 0.0013$; SRP: $p < 0.0001$). SNOT-20 GAV and NOSE scores were reduced after both surgical procedures (NOSE: SPL, $p < 0.0001$, SRP, $p < 0.0001$; SNOT-20 GAV: SPL, $p = 0.0068$, SRP, $p < 0.0001$). Evaluation of participant satisfaction in a self-established feedback questionnaire revealed a motivation of 81% in participants to redo the surgery (SPL, 13/16; SRP, 34/42) and a notably general satisfaction of 86% for SPL and 80% for SRP. The authors concluded that rhinosurgery leads to improved nasal breathing and increased disease-specific satisfaction quantitatively. Further research, with RCTs, is needed to validate these findings.

Floyd et al. (2017) completed a systematic review and meta-analysis of studies evaluating functional rhinoplasty outcomes with the NOSE score. A search by the authors was performed with the terms ‘‘nasal obstruction’’ and ‘‘rhinoplasty.’’ Studies were included if they evaluated the effect of functional rhinoplasty on nasal obstruction with the NOSE score. Case reports, narratives, and articles that did not use the NOSE score were excluded. Functional rhinoplasty was defined as surgery on the nasal valve. The search resulted in 665 articles. After dual-investigator independent screening, 16 articles remained. Study results were pooled with a random-effects model of meta-analysis. Change in NOSE score after surgery was assessed via the mean difference between baseline and postoperative results and the standardized mean difference (SMD). Heterogeneity was assessed and reported through the $I^2$ statistic. Individuals in the included studies had moderate to severe nasal obstructive symptoms at baseline. The NOSE scores were improved at 3 to 6, 6 to 12, and ≥ 12 months, with absolute reductions of 50 points (95% CI, 45-54), 43 points (95% CI, 36-51), and 49 points (95% CI, 39-58), respectively. All these analyses showed high heterogeneity. The authors concluded that nasal obstruction, as measured by the NOSE survey, is reduced by 43 to 50 points (out of 100 points) for 12 months after rhinoplasty. However, the study is limited due to a heterogeneous population of individuals, large variability in outcomes beyond 12 months, and potential for bias in observational studies.

## *Clinical Practice Guidelines*

### American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)

A clinical practice guideline developed by the AAO-HNS states that rhinoplasty is often performed to enhance function by improving nasal respiration and relieving congenital or acquired obstruction. The AAO-HNS definition of rhinoplasty, documented by Ishii et al. (2017), states that rhinoplasty is a surgical procedure that alters the shape or appearance of the nose while preserving or enhancing the nasal airway. The change in appearance may be a consequence of addressing a functional abnormality (e.g., deviated septum, nasal valve compromise) and for cosmetic purposes (e.g., an incidental cosmetic procedure). The primary reason for surgery can be aesthetic, functional, or both, and it may include adjunctive procedures on the nasal septum, nasal valve, nasal turbinates, or paranasal sinuses. When these adjunctive procedures are performed without an impact on nasal shape or appearance, they do not meet the definition of rhinoplasty and are therefore excluded from further consideration in the guideline.

### American Cleft Palate Craniofacial Association (ACPA)

The ACPA updated their standards for the evaluation and treatment of patients with cleft lip/palate or other craniofacial differences under a project funded by the U.S. Public Health Service Department of Health and Human Services. They advise that primary rhinoplasty with or without limited SPL, should be performed at the time of the primary cleft lip surgery to address nasal distortion depending on the severity of the cleft lip, and nasal and/or septal reconstruction and skeletal correction of a retrusive mandible and/or maxilla may be done to achieve additional airway improvement. They further advise that earlier intervention, including rhinoplasty and nasal septal surgery, may be indicated for reasons of an airway problem or nasal tip difference and that the timing of the nasal surgery should be discussed with the patient and parents so that the goals are understood and expectations are realistic. (2025)

### American Society of Plastic Surgeons (ASPS)

The ASPS published a Nasal Policy Statement (2021) indicating that nasal surgery is considered reconstructive surgery and is medically necessary to improve nasal airway function, to treat or revise anatomical abnormalities caused by birth defects or disease, and to revise structural deformities resulting from trauma.

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The FDA classifies devices used for rhinoplasty and other sinus surgeries under product code LRC [instrument; ear, nose, and throat (ENT); and manual surgical]. This is a broad product code category that includes a variety of devices used in ENT surgeries (e.g., knives, hooks, injection systems, dilation devices). Additionally, this product code is 510(k) exempt. Although manufacturers may voluntarily submit product information via the 510(k) process, it is not a requirement. However, all manufacturers are required to register their establishment and submit a Device Listing form; these records can be viewed in the Registration and Device Listing Database (search by product code, device, or manufacturer name). Refer to the following website for more information: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed January 6, 2026)

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# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 05/01/2026 | **Coverage Rationale**<br>• Removed content/language pertaining to rhinophyma excision<br>• Removed language indicating the following procedures are considered unproven and not medically necessary due to insufficient evidence of safety and/or efficacy:<br>  ○ Absorbable polylactic acid nasal cartilage support implants [e.g., Latera Absorbable Nasal Implant (Stryker)] for supporting nasal upper and lower lateral cartilage<br>  ○ Nasal septal swell body (NSB) reduction for the treatment of nasal obstruction<br>  ○ Posterior nasal nerve or sphenopalatine ganglion ablation using any method (such as radiofrequency or cryoablation; e.g., RhinAer®, ClariFix™) for the treatment of chronic rhinitis<br>  ○ Radiofrequency treatment of nasal valves for the treatment of nasal airway obstruction (e.g., VivAer® ARC Stylus)<br>**Applicable Codes**<br>• Removed CPT/HCPCS codes 30117, 30120, 64999, and L8699<br>**Supporting Information**<br>• Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information<br>• Archived previous policy version MP.019.34 |

# Instructions for Use

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