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January 27, 2023

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Nancy Morden, MD, MPH
Medical Officer
United Healthcare
P.O. Box 30449
Salt Lake City, UT 84130-0440

Re: Policy Number CS107.AA; Rhinoplasty and Other Nasal Surgeries

Dear Dr. Morden,

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), we are contacting you regarding a recent revision to United Healthcare's (UHC) Policy CS107.AA -Rhinoplasty and Other Nasal Surgeries. A significant portion of our membership has expressed concern about this policy revision as UHC will now require a submucous resection inferior turbinate, partial or complete (CPT code 30140) along with reconstructive septoplasty (CPT code 30520) before they can proceed with a repair of nasal valve stenosis (CPT code 30465).

We would like to address the following specific coverage criteria contained in Policy CS107.AA:

Nasal Valve Procedures/Repair of Nasal Vestibular Stenosis or Alar Collapse are considered Reconstructive and medically necessary when all the following criteria are present:

- Other causes have been ruled out as the primary cause of nasal obstruction (e.g., sinusitis, allergic rhinitis, vasomotor rhinitis, nasal polyposis, adenoid hypertrophy, nasopharyngeal masses, nasal septal deviation, turbinate hypertrophy, and choanal atresia); and
- ***Nasal septal deviation and turbinate hypertrophy have been previously surgically treated and failed, or are not needed; and***
- Prolonged, persistent obstructed nasal breathing due to internal and/or External Nasal Valve compromise (refer to Definitions section); and
- Internal valve compromise due to collapse of the upper lateral cartilage and/or External Nasal Valve compromise due to collapse of the alar (lower lateral) cartilage resulting in an anatomic Mechanical Nasal Airway Obstruction that is a primary contributing factor for obstructed nasal breathing; and

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- Photos clearly document internal and/or external valve collapse as the primary cause of an anatomic Mechanical Nasal Airway Obstruction and are consistent with the clinical exam

Based on the above criteria, we are concerned some patients with nasal obstruction may end up having unnecessary nasal surgery given their individual clinical circumstances. In the majority of patients with valvular collapse or stenosis, visual and physical examination reliably identify both internal and external anatomic deficiencies causing obstructed breathing. In patients that need surgical correction with cartilage grafting to relieve the collapse/stenosis, the source of the graft is the septum, whether the septum is severely obstructive or symptomatically deviated or not. Since the policy would require a septoplasty before 30465 can be considered, enforcing the revised policy as outlined, has the potential to necessitate an additional graft donor site, such as the pinna, to fulfill the need for cartilage to reconstruct the nasal vestibular area since the septal cartilage will have been violated at the previously required septoplasty.

Patients who do not present with septal deviation or turbinate hypertrophy should not have to undergo surgical procedures to correct normal anatomy. Additionally, patients that do present with a clinically significant septal deviation and/or hypertrophy of the turbinates can also have mid-nasal and or alar collapse due to cartilaginous defects that will not be corrected by normalizing the septum and reducing the turbinates. There are patients in whom it is not clear which is the primary factor causing the airway obstruction in which a staged surgical plan may be appropriate.

We are also concerned with the stipulation that other causes have been ruled out as the **primary** cause of nasal obstruction. In patients with multiple causes of obstruction, determining which is the primary cause is not possible. There is no objective test to determine which factor is primary, making the requirement to rule out the primary cause a requirement that cannot be met. By making septoplasty (CPT code 30520) and turbinate reduction a pre-requisite *before* authorization of nasal valve reconstruction (CPT code 30465), as written Policy CS107.AA would potentially require the patient to undergo a second unnecessary procedure. The AAO-HNS strongly disagrees with this pre-requisite requirement. The policy change will subject certain patients to multiple individual procedures, incurring both increased risk and costs, and will lengthen the time to resolution of the airway obstruction.

For the reasons outlined above, **we respectfully ask UnitedHealthcare to reverse this harmful coverage policy change.** We appreciate the opportunity to collaborate with UnitedHealthcare on policies impacting our members and their patients. **We would like to discuss this policy as soon as possible to discuss the rationale and review the evidence dictating the policy change.**

We look forward to hearing from your office.

Sincerely,



James C. Denny III, MD
Executive Vice President and CEO