Clinical Policy: Infracture of the Inferior Turbinate

Reference Number: CP.VP.33
Last Review Date: 01/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Infracture of the inferior turbinate is a surgical procedure often performed at the time of nasolacrimal probing, with or without stent placement. This policy describes the medical necessity requirements for infracture of the inferior turbinate.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® (Centene) that infracture of the inferior turbinate is **medically necessary** when all of the following conditions have been met:

A. Epiphora secondary to a decrease in tear drainage with normal eyelid apposition; and
B. Prior failed nasal lacrimal probings, stent placement with probing and subsequent failure, previous mid-facial or nasal surgery/trauma, or patients with obvious abnormal mid-face/nasal architecture.

Background

Epiphora is caused by a disruption in the balance between tear production and tear drainage. The lacrimal drainage system is a continuous and complex membranous channel whose function is dependent on the interaction of anatomy and physiology. When faced with a patient who complains of tearing, the first step is to determine whether the epiphora is caused by an increase in lacrimation or a decrease in tear drainage. Trichiasis, superficial foreign bodies, eyelid malpositions, diseases of the eyelid margins, tear deficiency or instability, and cranial nerve V irritation may cause an abnormal increase in tear production. In the absence of these conditions, an abnormality in tear drainage is the most likely cause.

Abnormalities of tear drainage may be subdivided further into functional and anatomical. Functional failure is related to poor lacrimal pump function, which may be due to a displaced punctum, eyelid laxity, weak orbicularis, or cranial nerve VII palsy. Anatomical obstruction may occur at any point along the lacrimal drainage pathway and may be congenital or acquired.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Codes	Description
30930	Fracture nasal inferior turbinate(s), therapeutic

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
H04.221	Epiphora due to insufficient drainage, right side
H04.222	Epiphora due to insufficient drainage, left side
H04.223	Epiphora due to insufficient drainage, bilateral
H04.531	Neonatal obstruction of right nasolacrimal duct
H04.532	Neonatal obstruction of left nasolacrimal duct
H04.533	Neonatal obstruction of bilateral nasolacrimal duct
H04.551	Acquired stenosis of right nasolacrimal duct
H04.552	Acquired stenosis of left nasolacrimal duct
H04.553	Acquired stenosis of bilateral nasolacrimal duct

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	12/2019	12/2019
Converted to new template	05/2020	06/2020
Annual Review; Added CPT and ICD-10 codes; Updated references	12/2020	12/2020
Annual Review	12/2021	01/2022

References

1. Tan, Alexander D., M.D.; Rubin, Peter A. D., M.D.; Sutula, Francis C., M.D.; Remulla, Heidi D., M.D. Congenital Nasolacrimal Duct Obstruction, International Ophthalmology Clinics: October 2001 - Volume 41 - Issue 4 - p 57-69.
2. Vagge A, Ferro Desideri L, Nucci P, et al. Congenital Nasolacrimal Duct Obstruction (CNLDO): A Review. *Diseases*. 2018;6(4):96. Published 2018 Oct 22.
3. Petris C, Liu D. Probing for congenital nasolacrimal duct obstruction. Cochrane Database Syst Rev. 2017 Jul 12;7(7):CD011109.
4. Takahashi Y, Kakizaki H, Chan WO, Selva D. Management of congenital nasolacrimal duct obstruction. Acta Ophthalmol. 2010 Aug;88(5):506-13.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and

accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.