

Clinical Policy: Repair of Nasal Valve Compromise

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[Coding Implications](#)

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Description

Medical necessity guidelines for repair of nasal valve compromise.

NOTE: Per state requirements, any determination that a requested service or item is not medically necessary shall be made by a PHW/Centene Medical Director.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that repair of nasal valve compromise is **medically necessary** when meeting all of the following criteria:
 - A. Clinical findings of one or more of the following:
 1. Internal valve collapse or compromise of the upper lateral cartilage;
 2. External nasal valve compromise due to collapse of the lower lateral cartilage;
 - B. Complaints of obstructed breathing that resolve with the Cottle maneuver or lateralization of the upper lateral cartilage from inside the nose with an object (cotton swab, nasal speculum, outpatient nocturnal trial of external stents such as Breathe Right[®] nasal strips, or outpatient nocturnal trial of nasal dilators such as Max-Air Nose Cones[®] and Sinus Cones[®]);
 - C. Other causes of obstructed breathing have been ruled out (e.g., sinusitis, allergic rhinitis, nonallergic rhinitis, nasal polyps, adenoid hypertrophy, nasopharyngeal masses, septal deviation and turbinate hypertrophy);
 - D. Symptoms persist despite conservative treatment (e.g., nasal cones, external nasal dilator adhesive strips or a six-week trial of nasal steroids).
- II. It is the policy of health plans affiliated with Centene Corporation that absorbable nasal implant repair of nasal valve collapse (e.g., Latera[®]; CPT 30468) or temperature-controlled radiofrequency remodeling of the nasal valve (e.g., VivAer[®]; CPT 30469) is medically necessary when all of the following are met:
 - A. Member/enrollee has symptomatic nasal airway obstruction due to nasal valve collapse or compromise, documented by physical examination; and
 - B. Documentation demonstrates one or more of the following clinical findings:
 1. Internal nasal valve collapse or compromise of the upper lateral cartilage;
 2. External nasal valve compromise due to collapse of the lower lateral cartilage;
 3. Dynamic lateral wall insufficiency; and
 - C. Nasal obstruction improves with a nasal valve support maneuver or trial, including Cottle maneuver, modified Cottle/lateralization of the upper lateral cartilage from inside the nose, outpatient nocturnal trial of external stents (e.g., Breathe Right[®] nasal strips), or outpatient nocturnal trial of nasal dilators (e.g., Max-Air Nose Cones[®] or Sinus Cones[®]); and

- D. Other causes of obstructed breathing have been ruled out or adequately treated, including sinusitis, allergic rhinitis, nonallergic rhinitis, nasal polyps, adenoid hypertrophy, nasopharyngeal masses, septal deviation, and turbinate hypertrophy; and
- E. Symptoms persist despite conservative treatment, such as nasal cones, external nasal dilator adhesive strips, or a six-week trial of nasal steroids when clinically appropriate; and
- F. Procedure requested is limited to treatment of the nasal valve collapse/compromise and is not requested primarily for cosmetic indications; and
- G. One of the following:
 - 1. For CPT 30468, the request is for subcutaneous/submucosal lateral wall absorbable implant(s) for nasal valve collapse; or
 - 2. For CPT 30469, the request is for low-energy, temperature-controlled radiofrequency subcutaneous/submucosal remodeling for nasal valve collapse.

III. Nasal valve suspension surgery remains not medically necessary for the repair of nasal valve compromise because safety and efficacy have not been established.

Background

Nasal valve compromise (NVC), also known as nasal valve collapse, is a narrowing of the nasal passageway causing difficult, obstructed breathing. Reasons for NVC are often multifactorial and can be caused by structural weakness or collapse of the nasal valve due to injury or trauma, nasal surgery, chronic inflammation, congenital defects or the natural aging process. NVC may also present as a symptom of rhinitis, sinusitis, septal deviation or adenoid hypertrophy.^{1,2,3,4,5}

Epidemiology information proposes that up to 13% of patients with chronic nasal obstruction have NVC, and it is primarily a unilateral condition in as many as 88% of patients.⁶

Symptoms of NVC include difficulty inhaling through the nose, sensation of congestion, stuffiness, fullness or blockage, nasal bleeding, and snoring. Symptoms may become exacerbated at different times of the day, seasonally, with exposure to different environmental stimuli and in the supine position.¹

When diagnosing NVC there are several specific questions and tests a physician may use in addition to a thorough medical history and physical exam of the nose, nasal cavity, and nasopharynx.^{1,3}

Important medical history questions include:¹

- Location – Whether or not symptoms are unilateral or bilateral
- Time course – History of the nasal symptoms, including time of day and seasonal variation to rule out allergic processes
- Triggers – Allergic stimuli and airborne exposures
- Symptoms of rhinosinusitis – Facial pain or pressure, nasal congestion, dysosmia, headache, purulent nasal discharge
- Symptoms suggesting malignancy – Facial deformity, cranial nerve dysfunction, and unexplained epistaxis

- Intranasal drug use – Intranasal cocaine or overuse of topical nasal decongestant, such as oxymetazoline or phenylephrine
- Oral medications – Oral contraceptives, antithyroid medication, antihypertensive medication, antidepressants, and benzodiazepines
- Trauma – History of nasal trauma or previous nasal surgery, particularly rhinoplasty
- Medical history – Granulomatosis with polyangiitis, cystic fibrosis, sarcoidosis, and syphilis, and asthma

Specific tests indicated in cases of suspected NVC include:^{1,6}

- NOSE score (Nasal Obstruction Symptom Evaluation)
- Cottle's maneuver – Widening the nasal valve angle by pulling laterally on the cheeks and assessing for improvement in nasal breathing
- Bachman's maneuver – Widening and stabilizing the nasal valve using instruments simulating the effect of a surgical procedure while assessing the subjective impact on nasal breathing
- Nasal decongestant instillation
- Rhinomanometry
- Acoustic rhinometry
- Full assessment of facial nerves to detect denervation or paralysis
- Anterior rhinoscopy
- Nasal endoscopy
- Computed tomography (CT) scan of the nose and paranasal sinuses
- Peak nasal airflow

Surgical intervention is the primary treatment for NVC and typically consists of insertion of cartilage grafts to support the existing cartilage in the lateral nasal wall or alar rim.^{7,8,9} There is also consensus that, although a separate entity, correction of a deviated septum or hypertrophied turbinate can sometimes correct NVC.⁷

VivAer[®]

The Aerin[™] VivAer[®] procedure is a non-invasive, office-based procedure that employs low-dose radiofrequency (RF) energy to modify soft tissues of the nose with the intent of improving airflow for patients with nasal valve collapse (NVC). The Aerin[™] System automatically adjusts the power output to maintain target temperature for therapeutic benefit while sparing surrounding tissue, including mucosa. The RF energy allows tissue to be repositioned laterally and creates a coagulation lesion. As the lesion heals, the tissue retracts and stiffens to lessen the degree of obstruction, decrease the airflow resistance, and improve the inhaled flow of air through the nose. The device consists of a console and two styluses, one for nasal airway obstruction and one for chronic rhinitis.^{6,10}

Updated evidence for temperature-controlled radiofrequency (TCRF) remodeling of the nasal valve includes a long-term, prospective, multicenter, single-blind randomized controlled trial extension and an additional multicenter prospective 36-month follow-up study. Reported outcomes include sustained, clinically meaningful NOSE score improvement through 3 years,

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responder rates of approximately 83% to 89%, improvements in sleepiness and medication use, and no serious device- or procedure-related adverse events reported in long-term follow-up.^{20,21}

Based on the updated long-term evidence, TCRF nasal valve remodeling may be considered medically necessary when the member meets the nasal valve collapse criteria in this policy and the procedure is requested to treat functional nasal airway obstruction rather than cosmetic concerns.^{20,21}

Latera[®]

Latera[®] is an absorbable nasal implant used to support the upper and lower cartilage inside the lateral wall of the nose. It is placed under general anesthesia with a 16-gauge cannula via an endonasal access point. Over the course of approximately 12 months following placement, the implant is enveloped by fibrous tissue that helps to maintain stability and positioning. Within approximately 18 months, the implant will have been absorbed and replaced with fibrous collagen matrix that provides continued support. The system consists of the Latera Absorbable Nasal Implant and delivery device as well as an implant positioning guide intended to serve as an external visual planning aid prior to implant placement. The Implant is composed of a PLLA-PDLA copolymer.^{11,12}

Updated evidence for bioabsorbable nasal implants includes a systematic review/meta-analysis and RCT-derived long-term follow-up. The evidence reports reduced lateral wall motion, improved disease-specific quality of life, NOSE responder rates greater than 80% through 24 months, statistically significant mean NOSE score reductions, no serious device- or procedure-related adverse events in 24-month follow-up, and implant migration/retrieval in a minority of implanted participants. Professional society input from the American Rhinologic Society supports use of a bioabsorbable nasal implant for nasal obstruction due to nasal valve collapse and states that the procedure should not be considered experimental.^{17,18,19}

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 2025, 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 That Support Coverage Criteria

CPT [®] * Codes	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)

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CPT® Codes	Description
30469	Repair of nasal valve collapse with low energy, temperature-controlled (i.e., radiofrequency) subcutaneous/submucosal remodeling

CPT Codes That Do Not Support Coverage Criteria

CPT® Codes	Description
N/A	Nasal valve suspension surgery remains not medically necessary; no specific CPT code is listed in this policy.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New PHW Policy Interim update. Revised policy position for CPT 30468 and CPT 30469 from not medically necessary/experimental to medically necessary when criteria are met; added medical necessity criteria for bioabsorbable nasal implant and temperature-controlled radiofrequency nasal valve remodeling; moved CPT 30468 and 30469 to Codes That Support Coverage Criteria; updated Background and References based on submitted evidence.	04/26	7/24/2026

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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

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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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, 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: *Per state requirements, any determination that a requested service or item is not medically necessary shall be made by a PHW/Centene Medical Director.*

Note: For Medicare members/enrollees, 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.

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