

2010 Procedures Adult Criteria

Septoplasty (Custom) - UDOH^(1, 2)

Created based on InterQual Subset: Septoplasty

Version: InterQual® 2010

PATIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name	ID#	Phone#	
	Signature	Date		

ICD-9-CM: 21.5, 21.88

INDICATIONS (choose one and see below)

- ☐ 100 Nasal obstruction with deviated septum
- ☐ 200 Deviated septum with chronic maxillary rhinosinusitis
- ☐ 300 Deviated septum with recurrent acute maxillary rhinosinusitis
- ☐ 400 Deviated septum with recurrent epistaxis
- ☐ Indication Not Listed (Provide clinical justification below)

- ☐ 100 Nasal obstruction with deviated septum **[One]**
 - ☐ 110 Space between inferior turbinate and septum decreased by > 75%⁽³⁾
 - ☐ 120 Continued obstruction after intranasal corticosteroid spray ≥ 6 wks⁽⁴⁾
- ☐ 200 Deviated septum with chronic maxillary rhinosinusitis **[All]**^(5, 6)
 - ☐ 210 Deviated septum by PE **[One]**
 - ☐ 211 Septum touching middle turbinate
 - ☐ 212 Septum blocking middle meatus
 - ☐ 220 Symptoms ≥ 12 wks: **[Two]**
 - ☐ 221 Purulent nasal discharge
 - ☐ 222 Nasal congestion
 - ☐ 223 Facial pain/pressure/fullness
 - ☐ 224 Decreased sense of smell
 - ☐ 225 Headache
 - ☐ 226 Eye pain
 - ☐ 230 Chronic rhinosinusitis by CT **[One]**⁽⁷⁾
 - ☐ 231 Air fluid levels
 - ☐ 232 Mucosal thickening > 2mm
 - ☐ 233 Opacification

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- ☐ 240 Continued Sx/findings after Abx Rx $\geq$ 3 wks^(8, 9)
- ☐ 300 Deviated septum with recurrent acute maxillary rhinosinusitis [All]
 - ☐ 310 Deviated septum by PE [One]
 - ☐ 311 Septum touching middle turbinate
 - ☐ 312 Septum blocking middle meatus
 - ☐ 320 $\geq$ 4 episodes w/in 1 yr⁽¹⁰⁾
 - ☐ 330 $\geq$ 1 episode acute rhinosinusitis documented by CT⁽¹¹⁾
- ☐ 400 Deviated septum with recurrent epistaxis⁽¹²⁾

Notes

(1)-DEF:

A deviated nasal septum occurs when the septum, which divides the two sides of the nasal cavity, is displaced from a straight vertical alignment into an abnormal configuration.

(2)

Deviation of the nasal septum is a common cause of unilateral nasal airway obstruction and can block airflow or sinus drainage through one or both sides of the nose. Septal deviation may follow nasal and midfacial trauma (Cummings et al., Otolaryngology: head and neck surgery, 4th ed. 2005, p.4139). Some inherited developmental septal deformities may not be fully evident until the patient is older.

(3)

Compensatory hypertrophy of the contralateral inferior turbinate is frequently seen in patients with nasal obstruction and septal deviation. This is a counterbalanced mechanism that protects the more patent nasal side from the drying and crusting effects of excess airflow (Akoglu et al., Otolaryngol Head Neck Surg 2007; 136(3): 380-384). Correction of the deviated septum and trimming of the enlarged turbinate are often done at the same time to relieve obstructive complaints.

(4)

Continued obstruction is described as a septal deviation that causes nasal airway obstruction which is refractory to a trial of conservative medical management (e.g., intranasal corticosteroid spray, decongestants, antibiotics for infection). Conservative management may be with one or more treatments.

(5)-DEF:

Chronic rhinosinusitis is defined as the presence of two or more signs or symptoms of sinusitis (e.g., purulent nasal discharge, nasal obstruction or congestion, facial pain, pressure or fullness, decreased sense of smell) and documented inflammation that persists for greater than 12 weeks.

(6)

There has been lack of consensus on the diagnostic criteria for chronic rhinosinusitis. Historically, diagnosis has been based on history, PE, and CT scan, or on nasal endoscopy findings. The American Academy of Otolaryngology-Head and Neck Surgery consensus guidelines attempt to streamline the diagnostic criteria used for defining chronic rhinosinusitis (Rosenfeld et al., Otolaryngol Head Neck Surg 2007; 137(3 Suppl): S1-31).

(7)

CT can quantify the extent of inflammation based upon the opacification of the paranasal sinuses. Additionally, CT provides information about sinus anatomy, the osteomeatal complex, nasal septum, turbinates, and the extent of mucosal thickening (Cherry and Li, Am J Med 2008; 121(3): 185-189; Rosenfeld et al., Otolaryngol Head Neck Surg 2007; 137(3 Suppl): S1-31).

A normal sinus x-ray series has a negative predictive value of 90 to 100 percent, particularly for the frontal and maxillary sinuses; that is normal sinus film virtually rules out sinusitis.

The standard study is four-view sinus series that includes:

- **Waters view:** in which the occiput is tipped down (patient's chin and tip of the nose are against the film surface) to facilitate viewing of the maxillary and frontal sinuses;

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- **Caldwell view:** in which the forehead and tip of the nose are placed in contact with the film (this offers superior visualization of the frontal and ethmoid sinuses).

- **Lateral view:** in which the sphenoid sinus and the posterior frontal sinus wall are visualized; and

- **Submentovertex view:** in which the sphenoid sinuses and posterior ethmoid cells are visualized.

Opacification of the affected sinus without bone destruction is the typical finding. An air-fluid level may be seen if the films are taken with the patient in the upright position. *Thickening of the mucosa is a less specific finding for acute sinusitis, but is a common sequela of acute sinusitis and is the most common feature of chronic sinusitis.*

The positive predictive value of x-rays using opacification and air-fluid levels as end points is 80 to 100 percent, (that is if opacification or air-fluid levels are found, the diagnosis of sinusitis is correct between 80 and 100 percent of the time), but the sensitivity is low since only 60 percent of patients with acute sinusitis have opacification or air-fluid levels. .

A very well done study, using the standard criteria of air-fluid level, sinus opacity or mucosal thickening (greater than 6 mm) to diagnose sinusitis, demonstrated that a single Waters view had a high level of agreement with the complete sinus series. In this study, 88 percent of patients with sinusitis had maxillary disease. A single occipitomental (Waters) view in children has an overall accuracy of 87 percent in diagnosing acute sinusitis. In those few situations where x-rays are indicated, utilizing a single Waters view is preferred over the four-view study.

(8)

Adequate doses of antibiotics are necessary to penetrate the mucosa. Beta-lactamase producing organisms have varying prevalences in different geographic areas. Unless therapy is guided by C &S, administration of a beta-lactamase resistant antibiotic (e.g., trimethoprim-sulfisoxazole, amoxicillin clavulanate, cefuroxime) is essential prior to consideration of surgery. The use of oral decongestants may be useful adjunctive therapy.

(9)

Several randomized controlled trials have shown some evidence of effect in the use of topical nasal corticosteroids as an adjunctive treatment to oral antibiotics in the treatment of chronic rhinosinusitis without nasal polyps. The use of intranasal topical corticosteroid installations for treating chronic rhinosinusitis has also been studied. Further research is needed to evaluate the full effect of these treatment modalities (Fokkens et al., *Rhinology* 2007; 45(2): 97-101; Lund, *Otolaryngol Clin North Am* 2005; 38(6): 1301-1310, x).

(10)

Historically there has not been consensus on the frequency cutoff for the minimum number of episodes to confirm the diagnosis of recurrent acute rhinosinusitis. The American Academy of Otolaryngology-Head and Neck Surgery guidelines defines recurrent acute rhinosinusitis as at least 4 episodes of acute bacterial rhinosinusitis per year, with an absence of signs or symptoms of rhinosinusitis between episodes. Each episode should meet diagnostic criteria that includes up to 4 weeks of signs or symptoms of acute rhinosinusitis that are present 10 or more days beyond the onset of upper respiratory symptoms or that worsen within 10 days after initial improvement (Rosenfeld et al., *Otolaryngol Head Neck Surg* 2007; 137(3 Suppl): S1-S11).

(11)

CT is considered the gold standard for evaluation of the paranasal sinuses and allows for evaluation of inflammatory and mucosal disease, sinonasal polyposis, and anatomic obstruction.

(12)-DEF:

Epistaxis is a medical term for nosebleed. The nose is a part of the body that is very rich in blood vessels (vascular) and is situated in a vulnerable position on the face. As a result, any trauma to the face can cause bleeding which may be profuse. Nosebleeds can occur spontaneously when the nasal membranes dry out, crust, and crack, as is common in dry climates, or during the winter months when the air is dry and warm from household heaters. People are more susceptible if they are taking medications which prevent normal blood clotting (Coumadin, warfarin, aspirin, or any anti-inflammatory medication). Other predisposing factors include infection, trauma, allergic and non-allergic rhinitis, hypertension, alcohol abuse, and inherited bleeding problems. "Epistaxis" is a Greek word meaning "a dripping," especially of blood from the nose. WEBMD

The patient suffering epistaxis is instructed to breathe through the mouth, to sit quietly with the head tilted slightly forward to prevent blood from entering the pharynx, and to avoid swallowing blood. The bleeding may be controlled by pinching the soft part of the nose

firmly with the fingers; by inserting a cotton ball soaked in a topical vasoconstrictor and applying pressure to the skin on both sides of the nose, occluding the blood supply to the nostrils; or by placing an ice compress over the nose. If bleeding continues, the clots may be removed by suction. The nasal mucosa may be anesthetized with topical lidocaine, cauterized with a silver nitrate stick or an electrical cautery, and then sprayed with epinephrine. Cocaine derivative may be used as a potent temporary vasoconstrictor. Severe bleeding, especially from the posterior nasal septum, may be treated by inserting packing, which generally is left in place for 1 to 3 days. Persistent or recurrent profuse epistaxis may be treated by ligating an artery supplying the nose, such as the external carotid, ethmoid, or internal maxillary artery. Mosby's Medical Dictionary, 8th edition. ©2009, Elsevier.