



SEPTOPLASTY REVIEW TOOL

Prior Justification for Septoplasty

CPT code 30520 (Septoplasty or submucous resection with or without cartilage scoring, contouring with graft)

Fax this form to (585) 327-2275 or call (585) 325-3114 or 1 (800)999-3920 and select option #2
(Monday through Friday 8am – 4pm)

The completed faxed form will contain all the information for an authorization, the office will be called with the authorization number.

Patient/Member Information			
Last Name:	First Name:	DOB:	
Member ID no.:	Secondary insurance:		
Provider Information			
Provider:	Office phone number:	Fax:	Provider ID#
Date of Request:	Date of Surgery:	Hospital:	ICD 9 Code:

Indications – (choose one and see below)	
<input type="checkbox"/> Nasal obstruction with deviated septum <input type="checkbox"/> Deviated septum with chronic maxillary sinusitis <input type="checkbox"/> Indication not listed (provide clinical justification below)	<input type="checkbox"/> Deviated septum with acute maxillary sinusitis <input type="checkbox"/> Deviated septum with recurrent epistaxis
Nasal obstruction with deviated septum (BOTH)	Deviated septum with chronic maxillary sinusitis (ALL)
<input type="checkbox"/> Nasal obstruction by history <input type="checkbox"/> Space between inferior turbinate and septum (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Decreased by >75% <input type="checkbox"/> Decreased by 50% to 75% (BOTH) <ul style="list-style-type: none"> <input type="checkbox"/> continued obstruction after Rx <input type="checkbox"/> Intranasal corticosteroids spray > 6wks 	<input type="checkbox"/> Deviated septum by PE (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Septum touching middle turbinate <input type="checkbox"/> Septum blocking middle meatus <input type="checkbox"/> Symptoms (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Sinus/dental pain <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Facial pain/pressure <input type="checkbox"/> Findings (BOTH) <ul style="list-style-type: none"> <input type="checkbox"/> Sinusitis documented by CT (ONE) date: _____ <ul style="list-style-type: none"> <input type="checkbox"/> Air fluid levels <input type="checkbox"/> Mucosal thickening > 2mm <input type="checkbox"/> Opacification <input type="checkbox"/> Continued Sx/findings after abx Rx \geq 3 wks (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Appropriate C&S <input type="checkbox"/> Beta-lactamase resistant abx
Deviated septum with acute maxillary sinusitis (ALL)	Deviated septum with recurrent epistaxis
<input type="checkbox"/> Deviated septum by PE (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Septum touching middle turbinate <input type="checkbox"/> Septum blocking middle meatus <input type="checkbox"/> 3 episodes of acute maxillary within 1 year <input type="checkbox"/> Symptoms/Finding during episode (BOTH) <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Sinus/dental pain <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Facial pain/pressure <input type="checkbox"/> Findings (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Temperature > 100.4 F <input type="checkbox"/> Pus in nasal vault <input type="checkbox"/> Pain with palpation over sinus <input type="checkbox"/> \geq 1 episode acute sinusitis documented by CT (ONE) <ul style="list-style-type: none"> <input type="checkbox"/> Air fluid levels <input type="checkbox"/> Opacification 	

Narrative: (include details of any indication not listed, such as a nasal tumor, elaborate on specific abx courses)
Physician Signature: Date:

PLEASE NOTE: By signing above, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.