n05705

Balloon Sinuplasty

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

The purpose of this policy is to provide guidance for Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS) utilization management teams regarding medical necessity of balloon sinuplasty procedures.

Policy Detail:

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, or Individual and Family Policy to determine eligibility and coverage because Employer Group/Plan Sponsor and government contracts may vary.

I. Description
   A. Balloon Sinuplasty (also known as balloon catheter dilation surgery) is an outpatient procedure that is used for the treatment of blocked sinuses; endoscopic instruments are used to open the passages without cutting bone or tissue.

II. Medical Indicators/Criteria:
   A. Network Health considers the following criteria for a balloon sinuplasty procedure as medically necessary when the following criteria are met:
      1. Chronic rhinosinusitis for greater than 12 consecutive weeks or documentation of recurrent acute rhinosinusitis (four (4) or more occurrences in one (1) year) **AND** all of the following:
         a. Documented failure of medical therapy demonstrated by persistent upper respiratory symptoms despite treatment consisting of the following:
            i. A minimum of two (2) completed courses of different antibiotics; **AND**
            ii. A trial of at least 6 (six) consecutive weeks utilizing a steroid nasal spray (e.g. Nasonex, Veramyst); **AND**
            iii. Allergy evaluation and treatment **IF**:
               1. Documented diagnosis of allergic rhinitis; **AND**
               2. Symptoms have not responded to appropriate environmental controls, antihistamine nasal spray (e.g. Astepro, Patanase), and/or allergen immunotherapy (eg. Injections); **AND**
            iv. Nasal saline irrigations for at least six (6) consecutive weeks; **AND**

b. Radiographic confirmation following the above-mentioned treatments which demonstrated objective evidence of:
   i. Infection/sinusitis of the affected sinus(es); **OR**
   ii. Obstruction within the affected sinus(es); **OR**
   iii. Surrounding anatomy contributing to obstruction of the affected sinus(es) (Ex: deviated septum, facial fractures, polyps, turbinates)

III. Coverage
   A. Balloon sinuplasty procedure is a covered benefit when deemed medically necessary per the criteria listed above for the frontal, maxillary and/or sphenoid sinuses only.
   B. NHIC follows CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) for application to its Medicare Advantage membership when available.
   C. Balloon sinuplasty can be performed either as a stand-alone procedure or as part of functional endoscopic sinus surgery.

IV. Limitations/Exclusions
   A. Balloon sinuplasty procedure for all indications other than outlined above will be reviewed under Network Health's experimental, investigational and/or unproven process.

V. References

   A. American Rhinologic Society(ARS). Ostial balloon dilation position statement. January 28, 2023.Accessed August 23, 2023. Available at: https://www.american-rhinologic.org/index.php?option=com_content&view=article&id=494:ostial-balloon-dilation-position-statement&catid=26:position-statements&Itemid=197statements
   B. Piccirillo JF, Payne SC, Rosenfeld RM, et al. Clinical Consensus Statement: Balloon Dilation of the Sinuses. *Otolaryngology–Head and Neck Surgery*. 2018;158(2):203-214. doi:10.1177/0194599817750086
   C. MCG Ambulatory Care 27th edition Functional Endoscopic Sinus Surgery (FESS) (A-0185)

Regulatory Citations:

UM2

Related Documents:

None

CPT Codes:*

30117	Excision or destruction (e.g., laser), intranasal lesion; internal approach
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery

31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy
31295	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); maxillary sinus ostium, transnasal or via canine fossa
31296	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); frontal sinus ostium
31297	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); sphenoid sinus ostium
31298	Nasal/sinus endoscopy, surgical, with dilation (e.g., balloon dilation); frontal and sphenoid sinus ostia
31299	Unlisted procedure, accessory sinuses
	*CPT codes are subject to change as codes are retired or new ones are developed, this list may not be all inclusive.

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e. Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only.

Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

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Tori Kirby	Utilization Management	2
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