MEDICAL POLICY – 7.01.559
Sinus Surgery

BCBSA Ref. Policies: 7.01.105, 7.01.155

Effective Date: May 1, 2017
Last Revised: May 5, 2017
Replaces: N/A

RELATED MEDICAL POLICIES:
7.01.558 Rhinoplasty

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY | PRIOR AUTHORIZATION REQUIREMENTS

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Sinusitis refers to infection or inflammation of the sinuses, which are small openings in the bones of the face. Sinusitis may develop after a respiratory illness. Symptoms include a stuffy nose, facial pain and discharge from the nose. Most sinus infections will get better without any specific treatment. For some people, sinus symptoms may last for months, and this is called chronic sinusitis. Standard therapy to treat chronic sinusitis may include decongestants, antibiotics, saline irrigation and the use of nasal spray containing steroids. When chronic sinusitis does not respond to standard medical treatments, then surgery may be the next step. Surgery can usually be done in an outpatient setting using a small scope that allows the doctor to see changes and treat them with tiny cutting tools. A new technology which includes a balloon to dilate blocked sinuses may also be helpful for some types of sinusitis.

This policy outlines the history and therapies that are recommended before proceeding to a sinus surgery for chronic sinusitis. There are other sinus conditions that may need surgery as a treatment, and those are listed in the policy as well. Sinus surgery that is not performed in a hospital operating room requires health plan pre-approval.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs providers about when a service may be covered.
### Policy Coverage Criteria

#### Note:
This policy applies to individuals 19 years of age or older.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Necessity</th>
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</thead>
</table>
| **Recurrent acute bacterial rhinosinusitis**<br>Note: Depending on symptoms and imaging findings, medically necessary surgery could be unilateral or bilateral. | **Functional endoscopic sinus surgery (FESS) may be considered medically necessary when there have been:**  
- Four or more documented episodes of acute bacterial rhinosinusitis within 12 continuous months  
**AND**  
- Medical therapy consisting of the following has been tried and failed:  
  o At least one course of oral antibiotics of 10 – 14 days within the last six months  
**AND**  
  o Topical intranasal steroids for at least four consecutive weeks  
**AND**  
  o There is objective evidence of mucosal inflammation as demonstrated by one of the following:  
    ▪ Sinus computed tomography or magnetic resonance imaging showing significant mucosal thickening, polyps, opacification of the paranasal sinuses, sinus ostial obstruction;  
   **OR**  
    ▪ Nasal endoscopy showing purulent mucus in the middle meatus or ethmoid region, or polyps in the nasal cavity or middle meatus. |
| **Chronic rhinosinusitis with or without polyposis**<br>Note: Depending on symptoms and imaging findings, medically necessary surgery could be unilateral or bilateral. | **Functional endoscopic sinus surgery (FESS) may be considered medically necessary when:**  
- Chronic rhinosinusitis has been present for at least 12 continuous weeks  
**AND**  
- Medical therapy consisting of the following has been tried and failed:  
  o At least one 10 -14 day course of antibiotics within the last |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Necessity</th>
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</table>
| Chronic rhinosinusitis     | Balloon sinus ostial dilation may be considered medically necessary when the following criteria are met:  
  - Chronic rhinosinusitis symptoms have been present for at least 12 continuous weeks
  AND  
  - Medical therapy consisting of the following has been tried and failed:  
    o At least one 10-14 day course of antibiotics
  AND  
  - Topical intranasal steroids for at least eight consecutive weeks
  AND  
  - There is objective evidence of mucosal inflammation as demonstrated by one of the following:  
    ▪ Sinus computed tomography or magnetic resonance imaging showing significant mucosal thickening, polyps, opacification of the paranasal sinuses, sinus ostial obstruction;
  OR  
    ▪ Nasal endoscopy showing purulent mucus in the middle meatus or ethmoid region, or polyps in the nasal cavity or middle meatus. |

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medical Necessity</th>
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| Medical Necessity          | six months
  AND  
  o Topical intranasal steroids for at least eight consecutive weeks
  AND  
  o There is objective evidence of mucosal inflammation as demonstrated by one of the following:  
    ▪ Sinus computed tomography or magnetic resonance imaging showing significant mucosal thickening, polyps, opacification of the paranasal sinuses, sinus ostial obstruction;
  OR  
    ▪ Nasal endoscopy showing purulent mucus in the middle meatus or ethmoid region, or polyps in the nasal cavity or middle meatus. |
<table>
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<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>Revision surgery</td>
<td><strong>Functional endoscopic sinus surgery (FESS) may be considered medically necessary for revision surgery when the following criteria are met:</strong></td>
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<tr>
<td></td>
<td>• At least 12 weeks have passed since previous surgery</td>
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<tr>
<td></td>
<td>• Chronic rhinosinusitis has been present for at least 12 continuous weeks</td>
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<tr>
<td></td>
<td>• Medical therapy consisting of the following has been tried and failed:</td>
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<td>• At least one 10 -14 day course of antibiotics since the previous surgery</td>
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<tr>
<td></td>
<td>• Use of topical intranasal steroids and/or saline nasal irrigation for at least eight weeks since the previous surgery</td>
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<td></td>
<td>• There is objective evidence of mucosal inflammation as demonstrated by one of the following:</td>
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<td>• Sinus computed tomography or magnetic resonance imaging showing significant mucosal thickening, polyps, opacification of the paranasal sinuses, sinus ostial obstruction;</td>
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<td>• Nasal endoscopy showing purulent mucus in the middle meatus or ethmoid region, or polyps in the nasal cavity or middle meatus.</td>
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<td><strong>Note:</strong> See Prior Authorization Requirements for explanation of what is needed.</td>
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<tr>
<td></td>
<td>• Multiple nasal polyps (aka antrochoanal polyps)</td>
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<td>• Cerebrospinal fluid (CSF) leak closure</td>
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<td>• Choanal atresia repair</td>
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<td>• Dacryocystorhinostomy (DCR)</td>
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<td>• Epistaxis control</td>
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<td></td>
<td>• Excision of selected tumors</td>
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<td></td>
<td>• Foreign body removal</td>
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<td></td>
<td>• Optic nerve</td>
</tr>
</tbody>
</table>
### Condition

- Medical Necessity
  - decompression
  - Orbital decompression (e.g., Graves ophthalmopathy)
  - Recurrent sinusitis in people who have cystic fibrosis or severe asthma
  - Sinus mucoceles
  - Sinus disease has eroded into the bone

### Coding

#### CPT

<table>
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<th>Code</th>
<th>Description</th>
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<tr>
<td>31254</td>
<td>Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)</td>
</tr>
<tr>
<td>31255</td>
<td>Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)</td>
</tr>
<tr>
<td>31256</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy;</td>
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<tr>
<td>31267</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus</td>
</tr>
<tr>
<td>31276</td>
<td>Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus</td>
</tr>
<tr>
<td>31287</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy;</td>
</tr>
<tr>
<td>31288</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus</td>
</tr>
<tr>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine fossa</td>
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<td>31296</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g., balloon dilation)</td>
</tr>
<tr>
<td>31297</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g., balloon dilation)</td>
</tr>
<tr>
<td>31299</td>
<td>Unlisted sinus procedure</td>
</tr>
</tbody>
</table>
Definition of Terms

**Recurrent acute rhinosinusitis:** Four or more acute episodes per year of acute bacterial rhinosinusitis, without persistent symptoms between episodes.

**Rhinosinusitis:** Symptomatic inflammation of the paranasal sinuses and nasal cavity. The term rhinosinusitis is preferred because sinusitis is almost always accompanied by inflammation of the contiguous nasal mucosa. Rhinosinusitis may be further classified by duration.

- **Acute rhinosinusitis:** Symptoms lasting less than 4 weeks.
  - May be further classified into acute bacterial rhinosinusitis versus acute viral rhinosinusitis
  - Cardinal symptoms include nasal obstruction, facial pain-pressure, purulent nasal drainage

- **Chronic rhinosinusitis:** Symptoms lasting more than 12 weeks, with or without acute exacerbations. This is characterized by two or more symptoms, one of which is nasal blockage/obstruction/congestion or nasal discharge (anterior/posterior nasal drip), with or without facial pain/pressure and reduction or loss of smell with endoscopic evidence of mucopurulence, edema, and/or polyps and/or CT presence of mucosal thickening or air-fluid levels in the sinuses.

**Uncomplicated versus complicated rhinosinusitis:** Complicated indicates clinical extension of inflammation outside the paranasal sinuses and nasal cavity at the time of diagnosis.

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**Evidence Review**

**Background**

Chronic rhinosinusitis (CRS) is a common chronic condition associated with significant morbidity. Functional endoscopic sinus surgery (FESS) involves the removal of varying amounts of tissue and the opening of sinus ostia to treat CRS in individuals who have failed medical therapy.

For individuals with CRS with or without nasal polyposis who receive FESS, the evidence includes randomized controlled trials and systematic reviews. Relevant outcomes are symptoms, change
in disease status, quality of life, and treatment-related morbidity. A small number of trials, with methodologic limitations, generally have not reported clinically significant differences in symptom improvement with FESS compared with medical therapy. Two Cochrane reviews on FESS for CRS with and without nasal polyposis have reported that FESS can be accomplished safely, but clinical trials have not demonstrated significant improvements with FESS compared with medical therapy. The evidence is insufficient to determine the effects of the technology on health outcomes.

Functional endoscopic sinus surgery (FESS) is a minimally invasive, mucosal-sparing surgical technique used to treat medically refractory chronic rhinosinusitis with or without polyps or recurrent acute rhinosinusitis. Rigid endoscopes are employed to visualize the surgical field to achieve one or more of the following goals: (1) to open the paranasal sinuses to facilitate ventilation and drainage from the paranasal sinuses; (2) to remove polyps and/or osteitic bony fragments to reduce the inflammatory load; (3) to enlarge the sinus ostia to achieve optimal instillation of topical therapies; and (4) to obtain bacterial or fungal cultures and tissue for histopathology. In the majority of cases, the surgical procedure is performed entirely through the nostrils, leaving no external scars.

Balloon ostial dilation is proposed as an alternative to traditional endoscopic sinus surgery for patients with chronic sinusitis who fail medical management. The procedure involves placing a balloon in the sinus ostium and inflating the balloon to stretch the opening. It can be performed as a stand-alone procedure or as an adjunctive procedure to functional endoscopic sinus surgery (FESS).

Summary of Evidence

A Cochrane review in 2006 of FESS found limited evidence. The available evidence suggests that FESS as practiced in the included trials has not been demonstrated to confer additional benefit to that obtained by medical treatment in chronic rhinosinusitis. There were no major complications in any of the included trials and FESS appears to be a safe procedure. More randomized controlled trials comparing FESS with medical and other treatments, with long-term follow-up are needed.²

Li et al. evaluated the therapeutic effects of functional endoscopic sinus surgery in patients with chronic rhinosinusitis who were unresponsive to medical treatment. 232 patients were divided into 2 groups: a functional endoscopic sinus surgery group (n=162) and a conservative therapy group (n=70). Efficacy was assessed in terms of Lund-Kennedy endoscopy scores and Sino-Nasal Outcome Test 20 symptom scores. In the functional endoscopic sinus surgery group, Lund-
Kennedy and Sino-Nasal Outcome Test 20 scores were significantly lower at 3, 6 and 12 months post-surgery compared with baseline scores. In the conservative therapy group, both sets of scores were significantly lower at 3 months, but not at 12 months. In this latter group, the Lund-Kennedy scores decreased only slightly and the Sino-Nasal Outcome Test 20 scores significantly decreased at six months compared with initial scores, indicating disparity between the subjective and objective measures. Patient-reported symptom improvement was better in the functional endoscopic sinus surgery group than in the medication group at 12 months (p<0.001). The authors concluded the findings suggest that functional endoscopic sinus surgery has better efficacy over a longer period compared with conservative therapy.3

Bachert performed an evidence review of the literature and guidelines of nasal polyposis. Based on the review, current treatment modalities include intranasal steroids, oral corticosteroids, and surgery. Surgery is generally limited to those with an insufficient response to medical treatment. Clinical data suggest intranasal steroids are effective in reducing polyp size and relieving nasal symptoms. Treatment with these mainstay options has been found to improve symptoms and quality of life.4

The European Position Paper on Sinusitis (EPOS) guidelines provide composite criteria to evaluate chronic rhinosinusitis (CRS) control, taking into consideration the severity of patients’ symptoms, aspect of nasal mucosa and medical intake as parameters of CRS control.

Adult CRS patients (n = 560) who had undergone bilateral FESS for chronic inflammatory sinonasal disease 3-5 years prior were studied. Patients received a postal questionnaire asking for control items according to EPOS control criteria, visual analogue scale (VAS) scores for total and individual sinonasal symptoms, sinonasal outcome test (SNOT)-22 and Short Form (SF)-36 questionnaires.

About 19.5% of CRS patients were well controlled, with 36.8% of patients being partly controlled and 43.7% uncontrolled. The levels of control corresponded to mean total VAS, SNOT-22 and SF-36 scores. Subgroup analysis revealed that female gender, aspirin intolerance and revision FESS were associated with higher prevalence of uncontrolled CRS, whereas allergy, asthma and smoking status did not alter the percentage of patients in each category of control. In 81 patients attending the outpatient clinic, nasal endoscopy changed classification in only four patients (4.9%).

Based on the novel EPOS control criteria, at least 40% of CRS patients are uncontrolled at 3-5 years after FESS. Therefore, better treatment strategies leading to higher disease control are warranted in CRS care.5
In 2011 Mendelsohn et al. performed a cohort study using a survival analysis technique. Records were reviewed of 549 patients with nasal polyposis who underwent endoscopic sinus surgery over a 10-year period. They found revision surgery occurs at a high rate, especially in patients with asthma, Samter’s triad, or frontal sinus disease. They concluded patients should be informed during clinical consults about the likelihood of recurrence.

Systematic Reviews of Balloon Ostial Dilation as a Stand-Alone or Adjunct Procedure

A TEC Assessment was completed in 2012 titled “Balloon Ostial Dilation for Treatment of Chronic Rhinosinusitis”. This Assessment reviewed evidence from one RCT, three nonrandomized comparative studies, and nine case series. The following conclusions were made concerning the adequacy of this evidence for determining the effect of balloon sinus ostial dilation on outcomes.

The Assessment concluded that the evidence was insufficient to determine the effect of the technology on health outcomes. One RCT comparing balloon sinus ostial dilation with FESS was inadequately powered and did not evaluate differences in outcomes between the 2 treatments. While most nonrandomized comparative studies of balloon sinus ostial dilation and FESS showed no difference in health outcomes between the two treatments, confounding factors may have biased the comparison of the 2 treatments. Several case series showed improvement in symptoms of rhinosinusitis over baseline measures, and such improvement appeared durable up to 2 years. Case series did not allow conclusions regarding the comparative efficacy of balloon sinus ostial dilation to FESS.

A Cochrane systematic review on balloon sinus ostial dilation for chronic rhinosinusitis (CRS) was published in 2011. This review concentrated on RCTs, and included the Plaza et al RCT as the sole controlled trial that met selection criteria. The authors rated this study as having a low risk for bias for most parameters, but a high risk for bias in reporting outcomes. They noted that symptom scores were not presented systematically and that details of statistical testing were not reported. The overall conclusion of this review was that there is no convincing evidence supporting the use of balloon sinus ostial dilation in CRS.

In 2011, Batra et al. performed a comprehensive review of the literature regarding balloon catheter technology (BCT) in rhinology. This review concluded:

“The accrued data attests to its safety, whereas the largest published observational cohort studies have demonstrated the ability to achieve ostia patency for up to 2 years. However,
because the selection criteria for these studies were not clearly defined, it is unclear if this data can be extrapolated to the general population with chronic rhinosinusitis (CRS). Is BCT superior or equivalent to the existing devices employed in FESS for the management of CRS? Will the use of BCT translate into improvements in patient outcomes, overall health, and/or quality of life? The many unsettled questions will be best answered by prospective randomized trials that directly compare FESS to BCT, or directly compare medical to surgical treatment.”

**Controlled Trials of Balloon Ostial Dilation as a Stand-alone Procedure versus FESS**

**Randomized Controlled Trials**

**REMODEL Trial**

The REMODEL study was an industry-sponsored study RCT (Cutler et al 2013) that compared balloon ostial dilation as a stand-alone procedure with FESS.\(^\text{11}\) A total of 105 patients with recurrent acute sinusitis or chronic sinusitis and failure of medical therapy were randomized to balloon ostial dilation or FESS. Balloon ostial dilation was performed with the Entellus device, which is labeled for a transantral approach. FESS consisted of maxillary antrostomy and uncinectomy with or without anterior ethmoidectomy. Thirteen patients withdrew consent before treatment, 11 in the FESS group (21%) and 2 in the balloon ostial dilation group (4%). The primary outcomes were the change in the Sino-Nasal Outcome Test (SNOT-20) score at 6-month follow-up, and the mean number of débridements performed post-operatively. Secondary outcomes included recovery time, complication rates, and rates of revision surgery. Both superiority and non-inferiority analyses were performed on these outcomes.

A total of 91 patients were available at 6-month follow-up. The improvement in the SNOT-20 score was 1.67±1.10 in the balloon dilation group and 1.60±0.96 in the FESS arm (p=0.001 for non-inferiority). Postoperative débridements were more common in the FESS group than in the balloon dilation group (1.2±1.0 in the FESS arm vs. 0.1±0.6 in the balloon ostial dilation arm, p<0.001 for superiority in the FESS arm). Patients in the balloon dilation arm returned to normal daily activities earlier (1.6 days vs. 4.8 days, p=0.002 for superiority), and required fewer days of prescription pain medications (0.9 days vs. 2.8 days, p=0.002 for superiority). There were no major complications in either group, and one patient in each group required revision surgery.

Bikhazi et al. reported 1-year follow-up from the REMODEL study in 2014.\(^\text{12}\) A total of 89 subjects (96.7%) were available for follow-up to 1 year. Improvement in the SNOT-20 score was
1.64 in the balloon dilation arm and 1.65 in the FESS arm (P<0.001 for noninferiority). During the year post-procedure, both the balloon dilation and FESS groups had fewer self-reported rhinosinusitis episodes (reduction of 4.2 episodes in the balloon arm, reduction of 3.5 episodes in the FESS; p=NS).

Another RCT by Bizaki (2016) compared balloon ostial dilation to FESS, with a focus on mucociliary clearance. It was conducted at the same institution as the previously reported 2014 Bizaki RCT; however, the RCT did not specify whether it was the same set of patients. This trial enrolled 36 patients who were randomized to balloon ostial dilation (n=17) or FESS (n=19); 7 patients dropped out (3 in the FESS group, 4 in the balloon ostial dilation group) and were not included in analyses. SNOT-22 scores improved in both groups from pre- to postoperative analyses. However, change in total SNOT-22 score did not differ significantly between groups. There was no significant change in mucociliary clearance before and after either treatment, nor was there a significant between-group difference in mucociliary clearance.

In 2015, Chandra et al. reported results up to 2 years post-procedure for subjects in the REMODEL study, along with an additional 30 subjects treated with either FESS or in-office balloon sinus dilation, for a total of 61 FESS patients and 74 balloon sinus dilation patients. Follow-up data were available for 130, 66, and 25 patients at 12, 18, and 24 months, respectively. Details about group-specific treatment received and loss to follow-up were not reported for the additional 30 patients not described in the 2013 Cutler article. Balloon sinus dilation patients required 0.2 débridements per patient, compared with 1.0 per patient in the FESS group (p<0.001). Mean change in SNOT-20 score from baseline to 12-month follow-up was -1.59 (p<0.001) and -1.60 (p<0.001) for the balloon sinus dilation and FESS groups, respectively, which was considered clinically significant. These changes were maintained at 24 months. At 18 months, overall revision rates were 2.7% and 6.9% in the balloon sinus dilation and FESS groups, respectively. In addition to the longer term results of the REMODEL trial, this article includes a meta-analysis including the REMODEL balloon dilation-treated patients and data from 5 manufacturer-sponsored trials, 3 of which had previously been reported in peer-reviewed form (BREATHE, Stankiewicz et al. [2010] and Stankiewicz et al. [2012]; RELIEF, Levine et al. [2013]; XprESS Transnasal Maxillary Multi-Sinus, Gould et al [2014]). Across the 6 studies, 846 patients were treated with balloon sinus dilation, including 121 not described in prior publications. In a random-effects model, overall mean and subscale values for the SNOT-20 score improved compared with baseline at every follow-up time point.

In January 2016, Chandra et al. reported on a meta-analysis of standalone balloon sinus dilation studies. The meta-analysis evaluated outcomes from six studies including 358 standalone balloon dilation patients with up to 24 months follow-up. Outcomes out to 2 years from the REMODEL full-study cohort is consistent with 6-month and 12-month outcomes. In the meta-
analysis of standalone balloon dilation studies, technical success is 97.5%, and mean 20-item Sino-Nasal Outcomes Test scores are significantly and clinically improved at all-time points (P < .0001). There are significant reductions (P < .0001) in work/school days missed, homebound days, physician/nurse visits, acute infections, and antibiotic prescriptions. Mean recovery time is 1.4 days. Comparison of 12-month symptom improvements and revision rates between the REMODEL FESS arm (n=59), REMODEL balloon dilation arm (n=71), and pooled single-arm standalone balloon dilation studies (n=243) demonstrated no statistical difference. Conclusions: All outcomes are comparable between FESS and balloon dilation at all-time points from 6 months to 24 months. Balloon dilation produces faster recovery, less postoperative pain, and fewer debridement’s than FESS. There is significant, durable benefit in a large series of 358 patients undergoing standalone balloon dilation.19

Additional RCTs

Bizaki et al. reported results from a small RCT that compared balloon ostial dilation with FESS among patients with symptomatic chronic or recurrent rhinosinusitis.20 The study enrolled 46 subjects, 4 of whom withdrew; the analysis included 42 patients (n=21 in each group). Both groups demonstrated significant improvements in SNOT-20 scores from baseline to postprocedure. There were no differences in change in total SNOT-30 scores between the balloon sinus dilation and FESS groups at 3 months post-procedure.

Marzetti et al. reported results from a small RCT that compared balloon ostial dilation using an unspecified device (or devices) with FESS in the treatment of sinus headache.21 The study included 83 patients with sinus headache, based on American Academy of Otolaryngology–Head and Neck Surgery definitions, 44 randomized to conventional endoscopic sinus surgery (ESS) and 35 to balloon ostial dilation. In the balloon dilation group, 23 patients were “only frontal sinus balloon” patients, in which balloon catheters were the only tools used for frontal sinus sinusotomy, and 12 were “hybrid,” in which balloon catheters and traditional ESS were used concurrently. It was not specified how patients were selected for these groups. At 6-month follow-up, scores on the SNOT-22 improved from 28.6 at baseline to 7.8 in the ESS group and from 27.3 at baseline to 5.3 in the balloon ostial dilation group, with a statistically significant reduction in both groups (P < 0.001). At 6-month follow-up, headache scores based on a visual analog scale (VAS) score improved from 6.5 at baseline to 5.4 in the ESS group and from 7.1 at baseline to 1.2 in the balloon ostial dilation group (P < 0.001).
Practice Guidelines and Position Statements

**American Academy of Otolaryngology-Head and Neck**

In 2015, the American Academy of Otolaryngology-Head and Neck Surgery Foundation published an update to their 2007 Clinical Practice Guidelines – Adult Sinusitis. The 14 recommendations address diagnostic accuracy for adult rhinosinusitis, the appropriate use of ancillary tests to confirm diagnosis and guide management (including radiography, nasal endoscopy, computed tomography, and testing for allergy and immune function), and the judicious use of systemic and topical therapy. Emphasis was also placed on identifying multiple chronic conditions that would modify management of rhinosinusitis, including asthma, cystic fibrosis, immunocompromised state, and ciliary dyskinesia.

**American Rhinologic Society**

A position statement, revised in 2015, from the American Rhinologic Society, stated that sinus ostial dilation is “an appropriate therapeutic option for selected patients with sinusitis.”

**National Institute for Health and Clinical Evidence**

A 2008 practice guideline on balloon catheter dilation of paranasal sinus ostia from the National Institute for Health and Clinical Evidence state: “Current evidence on the short-term efficacy of balloon catheter dilation of paranasal sinus ostia for chronic sinusitis is adequate and raises no major safety concerns. Therefore, this procedure can be used provided that normal arrangements are in place for clinical governance, consent and audit.”

In 2016, NICE published a recommendation on the use of the XprESS Multi-Sinus Dilation System for the treatment of chronic rhinosinusitis. “The case for adopting the XprESS multi-sinus dilation system for treating uncomplicated chronic sinusitis after medical treatment has failed is supported by the evidence. Treatment with XprESS leads to a rapid and sustained improvement in chronic symptoms, fewer acute episodes and improved quality of life which is comparable to functional endoscopic sinus surgery (FESS) XprESS should be considered in patients with uncomplicated chronic sinusitis who do not have severe nasal polyposis. In these patients, XprESS works as well as FESS, is associated with faster recovery times and can more often be done under local anesthesia.”


5. Van der Veen J, Seys SF, Timmermans M et al. Real-life study showing uncontrolled rhinosinusitis after sinus surgery in a tertiary referral centre, Allergy, 2016 Jul 8. PMID 27392210


27. Hamilos, DL. Management of chronic rhinosinusitis. In: UpToDate, Corren, J(Ed), Deschler D(Ed), UpToDate, Waltham, MA 2014.


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>12/08/14</td>
<td>New policy, add to Surgery section. Considered medically necessary as addressed in this policy. Policy held for provider notification and will be effective April 15, 2015.</td>
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<tr>
<td>03/20/15</td>
<td>Implementation delayed until July 1, 2015.</td>
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<td>04/05/15</td>
<td>Implementation delayed until August 15, 2015.</td>
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<td>04/13/15</td>
<td>Implementation delayed until August 18, 2015, to align with provider notification.</td>
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<tr>
<td>05/14/15</td>
<td>Implementation delayed until October 15, 2015 to facilitate appropriate provider notification.</td>
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<tr>
<td>06/17/15</td>
<td>Implementation delayed until December 30, 2015.</td>
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<tr>
<td>09/08/15</td>
<td>Interim review. Added references 8, 9. Expanded definitions for acute rhinosinusitis, subacute rhinosinusitis and chronic rhinosinusitis. Clarified maximal medical therapy in policy statements. Policy statements further defined from previous uncomplicated rhinosinusitis to recurrent acute bacterial rhinosinusitis and chronic rhinosinusitis with or without polyposis. Policy effective Jan. 1, 2016.</td>
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<td>12/16/15</td>
<td>Implementation delayed until May 1, 2016.</td>
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<tr>
<td>05/01/16</td>
<td>Annual review, changes approved April 18, 2016. Policy updated with the removal of “without medical review” for list of medically necessary indications other than recurrent acute bacterial rhinosinusitis and chronic rhinosinusitis; revision surgery was added to this list. No other changes.</td>
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<td>05/24/16</td>
<td>Update Related Policies. Remove 7.01.134 as it is archived.</td>
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<tr>
<td>07/01/16</td>
<td>Policy moved to new format. No change in content or coverage.</td>
</tr>
<tr>
<td>01/01/17</td>
<td>Interim review, changes approved December 13, 2016. Added clarification statement: Depending on symptoms and imaging findings, medically necessary surgery could be unilateral or bilateral. Revised need for antibiotic therapy from two courses to one course 10 – 14 days. Revised objective evidence requirements in policy statements. Clarified topical intranasal steroid use in consecutive weeks. Added policy statement with criteria for revision surgery. Added references 5, 6, 27. Removed CPT code 31237.</td>
</tr>
<tr>
<td>02/17/17</td>
<td>Updated title of Related Policy.</td>
</tr>
<tr>
<td>05/05/17</td>
<td>Revised Prior Authorization Requirements section.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and
local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2017 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

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**PRIOR AUTHORIZATION REQUIREMENTS**

**Clinical Information Requirements**

Please submit your patient’s information and clinical records listed below for a prior authorization request of functional endoscopic sinus surgery to this fax number: 800-843-1114.

All information must be submitted for prior authorization review to be completed.

**Coding**

Please indicate the codes to be reviewed with this request:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31254</td>
<td>Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)</td>
</tr>
<tr>
<td>31255</td>
<td>Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)</td>
</tr>
<tr>
<td>31256</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy;</td>
</tr>
<tr>
<td>31267</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus</td>
</tr>
<tr>
<td>31276</td>
<td>Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus</td>
</tr>
<tr>
<td>31287</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy;</td>
</tr>
<tr>
<td>31288</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the</td>
</tr>
<tr>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine fossa</td>
</tr>
<tr>
<td>31296</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g., balloon dilation)</td>
</tr>
<tr>
<td>31297</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g., balloon dilation)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Clinical Information Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recurrent Acute Bacterial Rhinosinusitis</strong></td>
<td>For requests for functional endoscopic sinus surgery, please submit documentation that confirms the following:</td>
</tr>
<tr>
<td></td>
<td>• Four or more documented episodes of acute bacterial rhinosinusitis in 12 continuous months</td>
</tr>
<tr>
<td></td>
<td>• Maximal medical therapy has been tried and failed:</td>
</tr>
<tr>
<td></td>
<td>• At least one course of oral antibiotics of 10 – 14 days within the last six months</td>
</tr>
<tr>
<td></td>
<td>• Use of topical intranasal steroids for a minimum of four consecutive weeks</td>
</tr>
<tr>
<td></td>
<td>• CT scan, MRI, or nasal endoscopy, during course of illness documents sinus pathology amenable to surgical treatment</td>
</tr>
<tr>
<td><strong>Chronic Rhinosinusitis with or without Polyposis</strong></td>
<td>For requests for functional endoscopic sinus surgery, please submit documentation that confirms the following:</td>
</tr>
<tr>
<td></td>
<td>• Chronic rhinosinusitis present for 12 or more continuous weeks</td>
</tr>
<tr>
<td></td>
<td>• Maximal medical therapy has been tried and failed:</td>
</tr>
<tr>
<td></td>
<td>• At least one course of oral antibiotics of 10 – 14 days within the last six months</td>
</tr>
<tr>
<td></td>
<td>• Use of topical intranasal steroids for a minimum of eight consecutive weeks</td>
</tr>
<tr>
<td>Condition</td>
<td>Clinical Information Required</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>• CT scan, MRI, or nasal endoscopy, during course of illness documents sinus pathology amenable to surgical treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Revision surgery</strong></td>
<td><strong>For requests for revision surgery, please submit documentation that confirms the following:</strong>&lt;br&gt;   o At least 12 weeks have passed since previous surgery&lt;br&gt;   <strong>AND</strong>&lt;br&gt;   o Chronic rhinosinusitis has been present for at least 12 continuous weeks&lt;br&gt;   <strong>AND</strong>&lt;br&gt;   o Medical therapy consisting of the following has been tried and failed:&lt;br&gt;       o At least <strong>one</strong> 10 -14 day course of antibiotics since the previous surgery&lt;br&gt;       <strong>AND</strong>&lt;br&gt;       o Use of topical intranasal steroids and/or saline nasal irrigation for at least eight weeks since the previous surgery&lt;br&gt;       <strong>AND</strong>&lt;br&gt;       o There is objective evidence of mucosal inflammation as demonstrated by one of the following:&lt;br&gt;           ▪ Sinus computed tomography or magnetic resonance imaging showing significant mucosal thickening, polyps, opacification of the paranasal sinuses, sinus ostial obstruction;&lt;br&gt;           <strong>OR</strong>&lt;br&gt;           ▪ Nasal endoscopy showing purulent mucus in the middle meatus or ethmoid region, or polyps in the nasal cavity or middle meatus.</td>
</tr>
<tr>
<td>• Multiple nasal polyps (aka antrochoanal polyps)&lt;br&gt;• Cerebrospinal fluid (CSF) leak closure&lt;br&gt;• Choanal atresia repair&lt;br&gt;• Dacryocystorhinostomy (DCR)&lt;br&gt;• Epistaxis control&lt;br&gt;• Excision of selected tumors&lt;br&gt;• Foreign body removal</td>
<td><strong>For requests for functional endoscopic sinus surgery, if any of one of the diagnoses is present, please submit clinical documentation supporting the diagnosis.</strong></td>
</tr>
<tr>
<td>Condition</td>
<td>Clinical Information Required</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
| - Optic nerve decompression  
- Orbital decompression (e.g., Graves ophthalmopathy)  
- Recurrent sinusitis in people who have cystic fibrosis or severe asthma.  
- Revision surgery  
- Sinus mucoceles  
- Sinus disease has eroded into the bone | |

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| Chronic Rhinosinusitis | For requests for balloon ostial dilation, please submit documentation that confirms the following:  
  - Chronic rhinosinusitis symptoms present for at least 12 continuous weeks  
  **AND**  
  - Maximal medical therapy has been tried and failed:  
    - At least one 10-14 day course of antibiotics  
    **AND**  
    - Topical intranasal steroids for at least 8 consecutive weeks  
    **AND**  
  - CT scan, MRI, or nasal endoscopy, during course of illness documents sinus pathology amenable to surgical treatment |
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at:

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.
Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Arabic):

Chinese (Chinese):
本通知有重要的讯息。本通知可能有关於您透过 Premera Blue Cross 提交的申请或保险的重要讯息。本通知可能有重要日期。您可能需要在截止日期之前採取行动。以保留您的健康保険或者费用補貼。您有權利免费以您的母語得到本訊息和幫助。請接電話 800-722-1471 (TTY: 800-842-5357).

Oromoo (Cushite):

Italiano (Italian):
Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas límite para que pueda hacer el servicio de atención de salud que precisa.

}}

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud de cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Ud. tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):

ไทย (Thai):
ประกาศนี้มีข้อความสำคัญ ประกาศนี้มีข้อความสำคัญเกี่ยวกับการทำงานของสิทธิ์ของคุณในการรับประกันสุขภาพของ Premera Blue Cross และการมีสิทธิ์ในการรับอุปกรณ์ที่คุณควรจะดูแลสุขภาพของคุณในยุคใหม่และได้รับการดูแลสุขภาพโดยมีการให้คำแนะนำให้รับอุปกรณ์และคำแนะนำเกี่ยวกับสุขภาพที่เป็นอนุรักษ์ใช้จ่าย โปรดติดต่อ 800-722-1471 (TTY: 800-842-5357).

український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані в цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дозвоніться за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):

Polskie (Polish):

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde e ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В этом уведомлении могут быть ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

한국어 (Korean):
본 통지서는 중요한 정보가 들어있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357)로 전화해주세요.

nihongo (Japanese):
この通報には重要な情報が含まれています。この通報には、Premera Blue Crossの申請または補償範囲に関する重要な情報が含まれています。この通報に記載されている情報は重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。0800-722-1471（TTY：800-842-5357）まで電話ください。