Clinical Policy: Sinus Procedures

Reference Number: LA.CP.MP.525c
Date of Last Revision: 07/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Sinuplasty, also known as balloon catheter sinusotomy or balloon sinus ostial dilation, is a minimally invasive technique intended to dilate the sinus ostia in patients with chronic sinusitis. Sinuplasty systems provide a means to dilate the sinus ostia and spaces within the paranasal sinus cavities for diagnostic and therapeutic procedures to open passages and to restore normal drainage. Balloon sinuplasty is proposed to treat patients with chronic sinusitis who have exhausted less aggressive treatment options. Functional endoscopic sinus surgery (FESS) is minimally invasive surgery for serious sinus conditions. Healthcare providers use nasal endoscopes — thin tubes with lights and lenses — to ease your sinus symptoms without making incisions in or around your nose. Functional endoscopic sinus surgery is also called endoscopic sinus surgery. Some healthcare providers use the term "functional" because the surgery is done to restore how your sinuses work, or function.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections that Balloon ostial dilation and functional endoscopic sinus surgery are considered medically necessary for the treatment of chronic rhinosinusitis when **all of** the following criteria are met:

A. Uncomplicated chronic rhinosinusitis limited to the paranasal sinuses without the involvement of adjacent neurological, soft tissue, or bony structures that has persisted for at least 12 weeks with at least two of the following sinonasal symptoms:
   1. Facial pain/pressure;
   2. Hyposmia/anosmia;
   3. Nasal obstruction;
   4. Mucopurulent nasal discharge.

B. Sinonasal symptoms are persistent after maximal medical therapy has been attempted, as defined by **all of** the following, either sequentially or overlapping:
   1. Saline nasal irrigation for at least six weeks;
   2. Nasal corticosteroids for at least six weeks;
   3. Approved biologics, if applicable, for at least six weeks;
   4. A complete course of antibiotic therapy when an acute bacterial infection is suspected; and
   5. Treatment of concomitant allergic rhinitis, if present.

C. Objective evidence of sinonasal inflammation as determined by **one** of the following:
   1. Nasal endoscopy; or
   2. Computed tomography

II. It is the policy of Louisiana Healthcare Connections that balloon ostial dilation and functional endoscopic sinus surgery **are not covered** and **not considered medically necessary** in the following situations:

A. Presence of sinonasal symptoms but no objective evidence of sinonasal disease by nasal endoscopy or computed tomography;

B. For the treatment of obstructive sleep apnea and/or snoring when the above criteria are not met;

C. For the treatment of headaches when the above criteria are not met; and
D. For balloon ostial dilation only, when sinonasal polyps are present.

III. It is the policy of Louisiana Healthcare Connections that reimbursement for sinus procedures is subject to post-payment review and recoupment in the event of non-compliance with this coverage policy.

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 2023, 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 and may not support medical necessity. 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	Description
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium
31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
New Policy. Original approval date	07/24	10/28/24	12/2/24

References

1. Louisiana Medicaid Managed Care Organization (MCO) Manual. Last Updated 3/3/2023. Pg. 170-171.

2. LDH Professional Services Provider Manual. 5.1: Covered Services. Sinus Procedures. Issued 02/10/22. Pg. 157.

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. LHCC 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.

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 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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.