Balloon Sinuplasty  
MPM 2.12

Disclaimer
Refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in these criteria.

Description
Balloon Sinuplasty is a technique in which surgeons use balloons to dilate the sinus ostia. It is an alternative technique to the use of microdebriders and forceps. This procedure relies on a disposable catheter that has a thin guidewire at its tip. Guided by X-ray images or by a lighted fiberoptic tip, the catheter is threaded up to the opening of the blocked or poorly draining sinus and the guidewire is passed through the opening of the sinus. The narrow width of the guidewire enables it to pass into sinuses that are partially or fully closed due to tissue swelling. Once the guidewire is in place, a balloon is passed over the wire and gently inflated to compress the tissue that is blocking the sinus opening. The balloon is then deflated and the catheter is removed. Balloon catheter sinusotomy is typically performed by an otolaryngologist on an outpatient basis, under general or local anesthesia. Balloon sinuplasty is intended for treatment of chronic or recurrent acute sinusitis in adult patients who have not responded adequately to conservative medical treatments such as decongestants and antibiotics. Balloon sinuplasty is generally limited to dilation of obstructed ostia in the frontal, sphenoid, and maxillary sinuses, but not in the ethmoid sinuses.

Coverage Determination
Prior Authorization is required regardless of the setting. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

It is recognized that the surgeon may choose to use balloon dilation as a tool in conjunction with traditional sinus surgery techniques. Balloon sinus ostial dilation used as an adjunct during endoscopic sinus surgery (FESS) is considered integral to the primary FESS procedure and not separately reimbursable. When requested in conjunction with the following codes for a procedure to be performed in an ambulatory surgical center (not an in-office procedure), the inclusion of balloon sinus ostial dilation will not be an indication for denial of traditional sinus surgery procedures:

- 30520 – Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
- 30140 – Submucous resection inferior turbinate, partial or complete, any method
- 31254 – Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)
- 31255 – Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and
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posterior)

31267 Nasal/sinus endoscopy, surgical; with removal of tissue from maxillary sinus

31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus

31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy;

31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus

Criteria

Balloon Sinuplasty may be covered when the following criteria are met:

1. For a diagnosis of chronic Rhinosinusitis when ALL of the following criteria are met:

   A. Absence of exclusion criteria as below

   B. A maximum of 2 ostea are to be dilated based on symptom and radiographic findings or endoscopic localization

      *requests for dilation of more than 2 ostea must be reviewed by medical director and may be approved on a case-by-case basis if indication is clear and absence of concomitant ethmoid sinus disease has been clearly demonstrated

   AND

   C. There is documentation of chronic rhinosinusitis that is present for greater than 12 continuous weeks

   AND

   D. There is documented failure of maximal medical therapy for combined total of at least 12 weeks, as demonstrated by persistent symptoms. Medical therapy must include:

      1. At least two completed courses of oral antibiotics from different classes given for the indication of sinusitis

         AND

      2. A trial of steroid nasal spray for at least 30 days

         AND

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E. Radiographic findings show BOTH:

1. In the sinuses to be intervened upon, findings consistent with chronic sinusitis, including at least one of the following:
   a) Air fluid levels
   b) Mucosal thickening >2mm
   c) Sinus opacification

   AND

2. Absence of significant ethmoid sinus disease

2. For a diagnosis of Recurrent Acute Sinusitis when ALL of the following criteria are met:

   A. Absence of exclusion criteria as below

   AND

   B. Member carries diagnosis of recurrent acute sinusitis and has documentation of 4 or more recurrent episodes of acute rhinosinusitis (ARS), with complete clearing of symptoms between episodes within a 6 month period; or 6 or more episodes with complete clearing of symptoms between episodes within a year).

   AND

   C. Each episode of acute rhinosinusitis meets the definition of ARS as follows with ALL of the following features:

   1. Inflammation of the mucosa of the nose and paranasal sinuses

      a) Requires documentation of physical exam/endoscopy findings of each episode

   2. Sudden onset of all of the following symptoms:

      a) purulent nasal drainage
      b) nasal obstruction,
      c) facial pain/pressure/fullness

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d) Symptom duration of up to 4 weeks duration.

AND

D. Each episode responded to a 1-3 week course of antibiotic therapy

E. Infections recur in spite of use of BOTH nasal steroid AND daily saline irrigations for at least 12 weeks duration with at least 2 episodes of acute recurrent sinusitis as defined above while on this treatment

AND

F. Imaging findings consistent with sinusitis or narrowing of drainage outflow tracts (ostiomeatal complex) of the sinuses to be intervened upon, such as (at least one):

- Air fluid levels
- Mucosal thickening >2mm
- Sinus opacification
- concha bullosa,
- Infraorbital or supraorbital ethmoid cells that narrow the drainage pathway of the maxillary or frontal sinuses respectively,
- Mucosal thickening at the ostiomeatal complex

AND

- If present, treatment of concomitant allergic rhinitis, including avoidance measures, pharmacotherapy, and/or immunotherapy.

AND

- Provider has given consideration to an immunological work up

Exclusions

Balloon sinuplasty will not be covered in the following circumstances:

A. Presence of significant polyposis or tumor

B. Presence of ethmoid sinus disease

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C. For requests for non-targeted 6-sinus procedures (bilateral maxillary, sphenoid, and frontal sinuses).

D. For members under age 18

E. Absence of radiographic imaging support

F. Requests for repeat procedures in members who have had prior balloon sinuplasty will require medical director review.

Coding

The coding listed in this Medical Policy is for reference only. Covered and non-covered codes are within this list.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa</td>
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<tr>
<td>31296</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)</td>
</tr>
<tr>
<td>31297</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)</td>
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<td>See codes listed page 1</td>
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<thead>
<tr>
<th>HCPCS© Codes</th>
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<table>
<thead>
<tr>
<th>ICD-10© Diagnosis Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>J32.0</td>
<td>Chronic Sinusitis Maxillary</td>
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<tr>
<td>J32.1</td>
<td>Chronic Sinusitis Frontal</td>
</tr>
<tr>
<td>J32.2</td>
<td>Chronic Sinusitis Ethmoidal</td>
</tr>
<tr>
<td>J32.3</td>
<td>Chronic Sinusitis Sphenoidal</td>
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</table>

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References:


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Approval Signatures: Clinical Quality Committee: ____________________________ Norman White MD

Medical Director: ____________________________ Pedro Cardona MD

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Publication History: 03-25-15: Original effective date
01-27-16: Annual Review. Change of ICD9-ICD10
08-12-16: Update to language re: Prior Auth required regardless of setting.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. This Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available on the Presbyterian Healthcare Services website at: http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm

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