Subject: Balloon Dilation for ENT Procedures

Medical Policy #: 2.12
Status: Reviewed

Original Effective Date: 03/25/2015
Last Review Date: 01/27/2021

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 this Medical Policy.

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.

PHS follows Hayes (Division of Tract Manager) findings for Eustachian tube dysfunction (ETD) is not a covered diagnosis. Currently available treatments for ETD may be ineffective and do not correct the underlying obstructive nature of ETD.

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

Benefit coverage is covered for Medicare, Medicaid and Commercial members based on the following.

Balloon Sinuplasty may be covered when the following clinical indications and 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
   and
   B. There is documentation of chronic rhinosinusitis that is present for greater than 12 continuous weeks
   and
   C. 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
   D. 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. If Ethmoid Sinus disease is present, the treatment plan for the Ethmoid Sinus needs to be documented, since the treatment of Balloon Dilation of the Ethmoid Sinus is not covered.

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

Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].
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
   and
   2. Sudden onset of all of the following symptoms:
      a. Purulent nasal drainage
d. Nasal obstruction,
c. Facial pain/pressure/fullness
   and
   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 two 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):
   1. Air fluid levels
   2. Mucosal thickening >2mm
   3. Sinus opacification
   4. Concha bullosa
   5. Infrarostral or supraorbital ethmoid cells that narrow the drainage pathway of the maxillary or frontal sinuses, respectively
   6. Mucosal thickening at the ostiomeatal complex
and
   1. If present, treatment of concomitant allergic rhinitis, including avoidance measures, pharmacotherapy, and/or immunotherapy.
   and
   2. Provider has given consideration to an immunological work up

Exclusion
Balloon Sinuplasty will not be covered in the following circumstances
A. The use of eustachian tube balloon dilation (ETBD) for the treatment of adult and pediatric eustachian tube dysfunction is non-covered.
B. For requests for non-targeted 6-sinus procedures (bilateral maxillary, sphenoid, and frontal sinuses).
C. For members 12 years and younger
D. Absence of radiographic imaging support
E. 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 (e.g., 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 (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>31298</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (e.g., balloon dilation)</td>
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Diagnostic endoscopy codes 31231-31235 may not be reported in conjunction with codes 31295-31298 (surgical endoscopy) when sinus endoscopy is performed on the same sinus as diagnostic endoscopy (31233 or 31235).
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61782
Stereotactic computer-assisted navigation may be used to facilitate the performance of endoscopic sinus surgery.

### ICD-10 Diagnosis Codes

<table>
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<tr>
<th>ICD-10 codes</th>
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<tbody>
<tr>
<td>J01.01</td>
<td>Acute recurrent maxillary sinusitis</td>
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<tr>
<td>J01.11</td>
<td>Acute recurrent frontal sinusitis</td>
</tr>
<tr>
<td>J01.21</td>
<td>Acute recurrent ethmoidal sinusitis</td>
</tr>
<tr>
<td>J01.31</td>
<td>Acute recurrent sphenoidal sinusitis</td>
</tr>
<tr>
<td>J01.81</td>
<td>Other acute recurrent sinusitis</td>
</tr>
<tr>
<td>J01.91</td>
<td>Acute recurrent sinusitis, unspecified</td>
</tr>
<tr>
<td>J31.0</td>
<td>Chronic rhinitis</td>
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<tr>
<td>J32.01 – J32.9</td>
<td>Chronic sinusitis. The – represents a range of codes; it is dependent on the specific diagnosis</td>
</tr>
<tr>
<td>J33.0 – J33.9</td>
<td>Nasal Polyp. The – represents a range of codes; it is dependent on the specific diagnosis</td>
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<tr>
<td>J35.02</td>
<td>Chronic adenoiditis</td>
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</tbody>
</table>

### References

3. Hayes, for Balloon Sinuplasty for treatment of Chronic Rhinosinusitis, in Adult Patients, Published September 26, 2019. [Cited 11/20/2020].
6. American Academy of Otolaryngology (AAO-HNS)-Head and Neck Surgery, Dilation of sinuses, any method (e.g. balloon, etc.) Policy Statement. Revised Approved 03/12/2017. Available at: [https://www.entnet.org/content/position-statement-dilation-sinuses-any-method-eq-balloon-etc](https://www.entnet.org/content/position-statement-dilation-sinuses-any-method-eq-balloon-etc). [Cited 11/20/2020]
8. Cigna, Balloon Sinus Ostial Dilation for Chronic Sinusitis and Eustachian Tube Dilation, Coverage Policy # 0480, Next review Date 04/15/2021. [Cited 11/20/2020]
9. Humana, Balloon Dilation (Eustachian Tube and Sinus) and Functional Endoscopic Sinus Surgery, Review Date: 02/27/2020, Policy Number: HCS-0309-019. [Cited 11/20/2020]

### Publication History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tr>
<td>03/25/15</td>
<td>New Policy. Original effective date. Use of a catheter-based inflatable device (balloon ostial dilatation) in the treatment of sinusitis</td>
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<tr>
<td>01/27/16</td>
<td>Annual review. Change of ICD-9 to ICD-10</td>
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<tr>
<td>07/24/18</td>
<td>Annual review. Medical policy name changed from Balloon Sinuplasty to Balloon Dilation for ENT Procedures</td>
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<tr>
<td>11/20/19</td>
<td>Annual review. Policy updated with literature review; reference 5, 7 &amp; 8 added and updated 1-5. No Medicare national coverage determination found, using term Sinuplasty. Hayes new report on PCRS was</td>
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</tbody>
</table>

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reviewed by Dr. Romero. No change to policy statement but changed “age under 18 are excluded” to members 12 years or younger are excluded.

01/27/21 Annual review. Reviewed by PHP Medical Policy Committee on 12/18/2020. No change. The criteria will remain for all LOB, since it’s still compatible with other payers and Hayes rating remains in good rating. Exclusion added: The use of eustachian tube balloon dilation (ETBD) for the treatment of adult and pediatric eustachian tube dysfunction (CPT 69705 & 69706) are non-covered. Error correction: Effective date is 03-25-2015 not 05-22-06. Will Continue PA for CPT code: 31295, 31296, 31297, 31298.

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. The 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 online at: Click here for Medical Policies

Web links:
At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.

Not every Presbyterian health plan contains the same benefits. Please refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage [MPMPPC051001].