



Balloon Sinuplasty for Treatment of Chronic Sinusitis Clinical Coverage Criteria

Overview

Balloon sinuplasty or as it is also known balloon ostial dilation, is a minimally invasive procedure used to treat chronic rhinosinusitis (CRS). Patients who suffer CRS typically have had inflamed and swollen sinuses for several weeks, this is characterized by issues with mucus build up.

First line treatment is for CRS is typically pharmaceutical in nature and surgical interventions are only considered for those who have failed pharmaceutical treatments. The typical surgical treatment for CRS is functional endoscopic sinus surgery (FESS) in which soft tissue and/or bone is removed to create openings from the sinuses into the nose.

Balloon sinuplasty utilizes a small balloon like device which is inflated in order to push sinus tissue and/or bones to allow a larger airway passage and assist with mucus drainage. This procedure can be done as a stand-alone procedure or in conjunction with a FESS procedure. When balloon sinuplasty is used with FESS in the same sinus cavity, it is considered an integral part of the primary procedure and not separately reimbursable.

Policy

This Policy applies to the following Fallon Health products:

- Commercial
- Medicare Advantage
- MassHealth ACO
- NaviCare
- PACE

Fallon Health follows guidance from the Centers for Medicare and Medicaid Services (CMS) for organization (coverage) determinations for Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and guidance in the Medicare manuals are the basis for coverage determinations. When there is no NCD, LCD, LCA or manual guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations.

Medicare does not have a National Coverage Determination (NCD) for balloon sinuplasty. National Government Services, Inc. does not have a Local Coverage Determinations (LCD) or Local Coverage Article (LCA) for balloon sinuplasty at this time (MCD search 06/15/2021).

For plan members enrolled in NaviCare, Fallon Health follows Medicare guidance for coverage determinations. In the event that there is no Medicare guidance or if the plan member does not meet medical necessity criteria in Medicare guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations for NaviCare members. Fallon Health's Clinical Coverage Criteria are developed in accordance with the definition of Medical Necessity in 130 CMR 450.204.

See Part II. below for covered indications for Autologous Stem Cell Transplantation for Medicare Advantage and NaviCare plan members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria are used to determine medical necessity for MassHealth members. Fallon Health Clinical Coverage Criteria are developed in accordance with the definition of Medical Necessity in 130 CMR 450.204.

Fallon Health Clinical Coverage Criteria

Fallon Health requires prior authorization for Balloon Sinuplasty. These requests must be supported by the treating provider(s) medical records. The below criteria must be met in order for approval:

1. The member must be 18 years of age or older
2. Clear documentation exists of chronic rhinosinusitis (CRS) lasting a minimal of 12 weeks via a physical exam as outlined below:
 - Complete anterior and posterior nasal examination (rhinoscopy after mucosal decongestion)
 - Examination of nasopharynx (if possible)
 - Nasal endoscopy
 - Dental, neurologic, ophthalmologic, and/or pulmonary evaluation may be required in cases of extrasinus involvement
3. Trial and failure of the pharmaceutical interventions inclusive of the below:
 - Oral antibiotics (if a bacterial infection is suspected)
 - Nasal steroid sprays
 - Systemic and/or topical steroids
 - Saline irrigations
 - Topical and/or systemic decongestants
 - Treatment of concomitant allergic rhinitis, including avoidance measures, pharmacotherapy, and/or immunotherapy
4. CT Scan to confirm CRS performed after failure of medical therapy which indicates one or more of the following:
 - Mucosal thickening
 - Bony remodeling
 - Bony thickening
 - Obstruction of the ostiomeatal complex

Exclusions

- Any use of balloon sinuplasty other than outlined above

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

Code	Description
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus

	ostium (eg, balloon dilation)
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)

References

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Policy history

Origination date: 11/01/2016
Approval(s): Technology Assessment Committee: 06/22/2016 (new policy), 07/26/2017 (updated references), 06/27/2018 (updated references) 12/01/2018 (added code 31298, policy was not reviewed at TAC), 06/26/2019 (updated references), 6/22/2021 (annual review, updated references; 06/15/2021:Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section).

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.