Corporate Medical Policy

Surgical Treatment of Sinus Disease

File Name: surgical_treatment_of_sinus_disease
Origination: 2/2010
Last Review: 8/2024

Description of Procedure or Service

Chronic sinusitis is one of the most frequently diagnosed chronic medical conditions. Chronic sinusitis is characterized by varying levels and combinations of nasal congestion or obstruction, discharge (usually without fever), facial pain and/or headache, and loss of sense of smell that persists for more than 12 weeks. Inflammation in the nose and sinuses result in thickening of mucosa may restrict or close natural openings between sinus cavities and the nasal fossae. Physical examination findings may include the presence of mucosal edema, thick discharge that may be purulent, and in some cases, nasal polyps. CT scan will often show mucosal thickening and/or bony remodeling of involved sinuses. A course of conservative medical therapy is attempted initially to resolve the symptoms; this treatment may include antibiotics, saline nasal irrigation, decongestants, and steroids.

In some cases of chronic sinusitis, surgery may be necessary. Functional endoscopic sinus surgery (FESS) is the most commonly used surgical technique to treat medically unresponsive chronic sinusitis and other serious conditions of the nasal sinuses that result in impaired sinus drainage and persistent inflammation. It involves the removal of varying amounts of polyps, tissue, and debris in the sinuses. The use of the endoscope permits a better view of the surgical field. Goals of FESS are to allow for maximum preservation of mucosa, to debride inflamed tissue and polyps, and to open and enlarge the sinus passageways allowing for proper drainage and optimizing access for topical medications.

FESS is performed using a rigid endoscope to view the structures of the nose and sinuses. The endoscope is inserted through the nose, as are the surgical instruments the surgeon uses to perform the surgery. The procedure can be performed under general or local anesthesia on an outpatient basis, or in the clinic/office setting, and individuals usually experience minimal discomfort. The use of FESS allows for a much less invasive and traumatic procedure than open or non-endoscopic sinus surgery. There are shorter surgery and healing times, less postoperative discomfort, and fewer surgical complications with FESS. However, because of the proximity of sinus structures to the eyes and the brain, it is not risk free.

Some form of sinus packing is frequently utilized postoperatively. Simple dressings, both absorbable and non-absorbable, can be inserted following surgery. These can serve as both hemostatic agents and/or middle meatal spacers. There is some RCT evidence that middle meatal spacers may reduce the formation of synechiae following FESS, although the available studies have significant heterogeneity in this outcome.

Implantable drug-eluting sinus implants are another option for postoperative management following FESS and other sinus procedures. These implants are inserted under endoscopic guidance to stabilize the sinus openings and the turbinates, reduce edema, reduce polyp recurrence, and/or prevent obstruction by adhesions. Currently available products also deliver medications (e.g., steroids) topically over an extended period of time (e.g., 30 days), and this local delivery of medications may be superior to other treatment options in the postoperative setting. Reducing postoperative inflammation and maintaining patency of the sinuses may be important in achieving optimal sinus drainage and may impact recovery from surgery and/or reduce the need for additional surgery. Close follow-up after surgery is important to ensure that long term patency of the sinuses and to minimize recurrence of inflammation.

Surgical Treatment of Sinus Disease

Regulatory Status
In 2011, the PROPEL® system (Intersect ENT, Palo Alto, CA) was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process. This device is a self-expanding, bioabsorbable, steroid-eluting stent intended for use in the ethmoid sinus. It is placed via endoscopic guidance using an applicator included with the device. Steroids (mometasone furoate) are embedded in a polyethylene glycol polymer, which allows sustained release of the drug over an approximate duration of 30 days. The device dissolves over several weeks, and therefore does not require removal. In 2012, a smaller version of the PROPEL® device, the PROPEL® mini Sinus Implant, was approved for use in individuals older than age 18 years following ethmoid sinus surgery to maintain patency and later expanded to the frontal sinus following frontal sinus surgery in 2016. In 2017, the PROPEL® Contour was approved through a premarket approval supplement. The PROPEL® Contour sinus implant is an adaptable implant that is designed to maximize drug delivery to the frontal and maxillary sinus.

In December 2017, the U.S. Food and Drug Administration (FDA) approved Sinuva (mometasone furoate) Sinus Implant under a New Drug Application with a new dose for the treatment of nasal polyps in individuals 18 years of age or older who have had ethmoid sinus surgery.

There are numerous other stenting and packing materials commonly used in sinus surgery. This policy does not apply to the use of those materials.

Related Policies:
Balloon Dilation of the Eustachian Tube
Balloon Ostial Dilation (Balloon Sinuplasty)
Maximum Units of Service

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

BCBSNC will cover surgical treatment of sinus disease when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When surgical treatment of sinus disease is covered

Functional endoscopic sinus surgery (FESS) is considered **medically necessary** for the treatment of sinusitis, polyposis, sinus tumor, or other conditions listed below when **any one or more** of the following circumstances is present:

1. Uncomplicated sinusitis and **all** of the following:
    a. Either four or more documented episodes of acute rhinosinusitis in one year, or chronic sinusitis that interferes with lifestyle; and,
    b. Optimal medical therapy has been attempted and failed; and,
    c. For chronic rhinosinusitis, documentation of coronal CT and/or nasal endoscopy following optimal medical therapy showing persistent sinus pathology; and,

   d. For recurrent acute rhinosinusitis, coronal CT and nasal endoscopy may be normal after treatment. However, CT and/or nasal endoscopy during acute rhinosinusitis should document sinus pathology amenable to surgical treatment.

2. Multiple or recurrent polyps with symptoms and failure of optimal medical management (including assessment for allergy symptoms and allergy evaluation if indicated) with persistent sinus disease on follow up CT scan and/or nasal endoscopy,

3. Complications of sinusitis, including extension to adjacent structures,

4. Mucocele (excludes benign, asymptomatic mucus retention cysts),

5. Recurrent sinusitis with significant associated comorbid conditions (some examples include immune system disorders, and congenital or acquired ciliary dyskinesia),

6. Recurrent sinusitis which exacerbates significant comorbid conditions (including but not limited to asthma, recurrent bronchitis or pneumonia, diabetes),

7. Multidrug resistant organisms identified by culture,

8. Sinonasal benign or malignant tumor (including inverted papilloma),

9. Cerebrospinal fluid leak (CSF leak) and/or meningoencephalocele,

10. Dacryocystorhinostomy (DCR) for disorders of the lacrimal system,

11. Orbital or optic nerve decompression,

12. Repair of choanal atresia.

13. Silent Sinus Syndrome

14. Antrochoanal Polyps

15. Fungal ball or mycetoma

16. Fungal Sinusitis

The use of a mometasone furoate sinus implant (e.g., Propel®, Propel Mini®, and Propel Contour®) is considered medically necessary following functional endoscopic sinus surgery (FESS) or other sinus procedure when the following criteria are met:

1. Individual is ≥ 18 years of age; AND
2. Ethmoid or frontal sinus surgery is planned; AND
3. Individual has one or more of the following conditions:
   a. Polypoid disease
   b. Failed prior surgery and/or restenosis
   c. Absolute or relative contraindication to systemic steroids
4. The functional endoscopic sinus surgery (FESS) or other primary sinus procedure is considered medically necessary.

When surgical treatment of sinus disease is not covered

Functional endoscopic sinus surgery for sinus disease is considered not medically necessary for the treatment of sinusitis or polyposis when the criteria above are not met.

The use of a mometasone furoate sinus implant (Propel®) is considered not medically necessary when the criteria above are not met.

A mometasone furoate sinus implant (Propel®) is contraindicated when:

- individual has suspected or confirmed intolerance to mometasone furoate.
- individual has a known hypersensitivity to lactide, glycolide, or caprolactone copolymers.

The use of a mometasone furoate sinus implant (Sinuva™) in the treatment of sinonasal polyposis is considered investigational.

Policy Guidelines

Optimal medical treatment
Functional endoscopic sinus surgery (FESS) should be reserved for use in individuals in whom optimal medical treatment has failed. Many individuals with sinusitis do not require surgery. Their sinus symptoms may be controlled medically, including antibiotic therapy and other medications, treatment of allergy, and environmental control.

Optimal medical treatment consists of the following:

1. Oral antibiotics of 2 weeks duration for individuals with chronic rhinosinusitis if evidence of bacterial infection on endoscopy
2. Oral antibiotics with multiple 1-2 week courses for individuals with recurrent acute rhinosinusitis
3. Intranasal steroids for at least one month
4. Systemic steroids (at the discretion of the physician)
5. Saline irrigations (optional)
6. Topical and/or systemic decongestants (optional, if not contraindicated)
7. Treatment of concomitant allergic rhinitis, including avoidance measures, pharmacotherapy, and/or immunotherapy (at the discretion of the physician)

Note: Imaging studies should be generally obtained after appropriate medical therapy. Based on the clinical situation (i.e., concern for sinus complications or neoplasm), early or emergent imaging may be required to confirm a diagnosis. Early imaging is also indicated in recurrent acute rhinosinusitis and in individuals with a primary symptom of headache.

Endoscopic Sinus Surgery in the Pediatric Population
Prior to performing endoscopic sinus surgery in the pediatric population, the following must be documented.

1. A comprehensive history
   a. Failure of medical management for chronic rhinosinusitis or recurrent acute rhinosinusitis, possibly in addition to other disorders, including, but not limited to:
      - Allergy
      - Day care exposure
      - Gastroesophageal reflux contributing to rhinosinusitis
      - Adenoiditis and/or obstructive adenoid hypertrophy
      - Cystic fibrosis
      - Immune deficiency disorders
      - Ciliary dysfunction/dyskinesia
      - Progressively worsening asthma with opaque sinus(es)
      - Nasal polyposis with airway obstruction and/or sinusitis

- Suspected neoplasm (e.g., juvenile nasopharyngeal angiofibroma)
- Adenoidectomy should be strongly considered a minimum of three months prior to performing pediatric sinus surgery for any of the above indications
- Intracranial complications
- Cavernous sinus thrombosis
- Mucocoeles and mucopyocoeles
- Subperiosteal or orbital abscess/periorbital cellulitis
- Traumatic injury to optic canal (decompression)
- Dacryocystitis from rhinosinusitis
- Meningocephaloceles
- Cerebrospinal fluid leaks
- Tumors of the nasal cavity, paranasal sinuses, orbit or skull base
- Recurrent acute rhinosinusitis (RARS)

2. Physical examination, including complete anterior and posterior nasal examination (rhinoscopy after mucosal decongestion) as possible for individual's age

3. Other tests, including for surgical planning, a coronal CT scan following medical therapy is required. A complete axial CT scan is recommended in cases with complex disease. MRI, culture and sensitivity, and allergy testing are optional.

4. Optimal medical therapy, including:
   a. Evaluation and management for all medical conditions listed above
   b. Treatment of rhinitis medicamentosa, when present
   c. Parental education of environmental factors including allergens, irritants, or secondhand tobacco smoke
   d. Antibiotic therapy when indicated
   e. Appropriate topical and/or systemic steroids when indicated

For individuals with uncomplicated CRS refractory to medical therapy who receive FESS, the evidence includes an RCT, a systematic review of non-randomized comparative studies, and additional non-randomized studies published since the systematic review. Relevant outcomes are symptoms, functional outcomes, change in disease status, quality of life, and treatment-related morbidity. One RCT was identified in patients who have failed therapy with nasal irrigation and corticosteroids. This RCT found that FESS was not superior to maximal medical therapy that includes antibiotics along with nasal irrigation and topical or systemic corticosteroids. Although no RCTs have been identified that evaluated FESS in patients with CRS who failed a regimen that included antibiotic therapy, a systematic review of non-randomized comparative cohorts and pre-post studies is available. This meta-analysis suggests that in patients who have failed maximal medical therapy (nasal irrigation, corticosteroids, and antibiotics), FESS can improve symptoms compared to continued medical management. Patients most likely to select and benefit from FESS are those with lower disease-specific quality of life. Multiple additional non-randomized studies further support improvements in quality of life and functional outcomes after FESS in this setting. Surgical treatment of CRS with FESS may thus be appropriate for individuals who meet diagnostic criteria for CRS and have failed maximal medical management. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Steroid-Eluting Sinus Stents as an Adjunct to Endoscopic Sinus Surgery
Drug-eluting sinus implants have been used post-FESS with the intent of maintaining patency of the sinuses and delivering local steroids. Two RCTs have compared the Propel™ device with steroids to the same device without steroids and reported that the steroid-eluting device reduced postoperative inflammation, reduced the need for oral steroids, and reduced the need for postoperative re-interventions. These trials evaluate the benefit of local steroid delivery in addition to standard care. The improvements reported in these trials reflect the impact of local steroid delivery, which was withheld in the control arm.

Steroid-Eluting Sinus Implant (Sinuva) for Recurrent Polyposis
Han et al (2014) reported on results from RESOLVE, a sham-controlled randomized trial evaluating the use of office-based placement of a mometasone-eluting nasal implant (Sinuva) for patients with recurrent nasal polyposis after endoscopic sinus surgery. Eligible patients had chronic rhinosinusitis, had undergone prior bilateral total ethmoidectomy more than 3 months earlier, had endoscopically confirmed recurrent bilateral ethmoid sinus obstruction due to polyposis that was refractory to medical therapy, and were considered candidates for repeat surgery based on the judgment of the surgeon and patient. Patients and those who administered symptom questionnaires at follow-up visits were blinded to treatment group. The trial was powered to detect a between-group difference of at least a 0.6-point change in polyp grade from baseline, and at least a 1.0-point change in nasal obstruction/congestion score. One hundred subjects were randomized to treatment (n=53) or control (n=47). For endoscopically measured outcomes, at 90 days of follow-up, the treatment group had a greater reduction in polyp grade than the control group (-1.0 vs -0.1; p=0.016) and a greater reduction in percent ethmoid obstruction on a 100-mm VAS (-21.5 mm vs 1.3 mm; p=0.001), both respectively. For patient-reported outcomes, there were no significant differences in change in nasal obstruction/congestion scores between groups. Compared with controls, fewer treatment group patients required oral steroids for ethmoid obstruction (11% vs 26%) and fewer treatment group patients were indicated for sinus surgery at 3 months based on established criteria (47% vs 77%), although statistical comparisons were not reported.

Forwith et al (2016) reported six-month follow-up results from the RESOLVE trial. Treated patients experienced improvement in Nasal Obstruction Symptom Evaluation (NOSE) score (p=0.02) and greater than 2-fold improvement in mean nasal obstruction/congestion score p=0.12). Endoscopically, treated patients showed reduction in ethmoid sinus obstruction (p=0.01) and a two-fold improvement in bilateral polyp grade (p=0.099).

The RESOLVE trial had a high risk of bias due to unblinded outcome assessment. Although avoidance of repeat endoscopic sinus surgery and oral steroids may be relevant outcomes for this indication, it would be more important if decisions about repeat surgery or other treatments were standardized and, in the trial setting, if decisions were prespecified or made by a clinician blinded to treatment group.

Kern et al (2018) reported on results from RESOLVE II, a sham-controlled, double-blind, randomized trial evaluating mometasone-eluting sinus implants in patients with recurrent polyposis after sinus surgery. Three hundred patients with refractory chronic rhinosinusitis with nasal polyps who were candidates for repeat surgery, were randomized to in-office bilateral placement of implants or sham procedure. Treated patients experienced reductions in both nasal obstruction/congestion score (p=0.007) and bilateral polyp grade (p=0.007), compared to controls. There was a 61% reduction in the need for repeat sinus surgery at 90 days in the treatment group versus 37% reduction among sham patients. Limitations to the study included absence of a defined medical regimen prior to enrollment, and the clinical investigators who performed the endoscopic grading and assessment for indication for repeat surgery at day 90 were not blinded to treatment assignment. Additional trials with longer follow-up beyond 90 days are needed to assess duration of the effect of the stent on recurrent nasal polyps.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 31237, *31241, 31253, 31254, 31255, 31256, 31257, 31259, 31267, 31276, 31287, 31288, 31299, J7402, S1091, S2342*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Rosenfeld RM, Andes D, Bhattacharyya N, et al. (June 2007). Clinical practice guidelines: Adult sinusitis. Otolarygol Head Neck Surg, 2007;137(3S):S1-S31. Available at: http://www.entnet.org/qualityimprovement/upload/Adult%20Sinusitis%20Guideline.pdf

American Academy of Otolaryngology-Head and Neck Surgery. Policy statement for Sinus Endoscopy. Available at: http://www.entnet.org/Practice/policySinusEndoscopy.cfm

Slack R, Bates G. (Sept 1998). Functional Endoscopic Sinus Surgery. Available at: http://www.aafp.org/afp/980901ap/slack.html

National Institute of Allergy and Infectious Diseases. Sinus Infection (Sinusitis). Available at: http://www.niaid.nih.gov/topics/sinusitis/Pages/Index.aspx

Medical Director review 2/2010

Medical Director review 7/2010

FDA Approval Letter. Available at http://www.accessdata.fda.gov/cdrh_docs/pdf10/p100044a.pdf

Medical Director review 6/2012

Rudmik L, Mace J, Mechor B. Effect of a dexamethasone SinuFoam™ middle meatal spacer on endoscopic sinus surgery outcomes: A randomized, double-blind, placebo-controlled trial. Int Forum Allergy Rhinol 2012; 2(3):248-251.

Berlucchi M, Castelnuovo P, Vincenzi A et al. Endoscopic outcomes of resorbable nasal packing after functional endoscopic sinus surgery: a multicenter prospective randomized controlled study. Eur Arch Otorhinolaryngol 2009; 266(6):839-45.

Cote DW, Wright ED. Triamcinolone-impregnated nasal dressing following endoscopic sinus surgery: a randomized, double-blind, placebo-controlled study. Laryngoscope 2010; 120(6):1269-73.

Freeman SR, Sivayoham ES, Jepson K et al. A preliminary randomised controlled trial evaluating the efficacy of saline douching following endoscopic sinus surgery. Clin Otolaryngol 2008; 33(5):462-5.

Rotenberg BW, Zhang I, Arra I et al. Postoperative care for Samter's triad patients undergoing endoscopic sinus surgery: a double-blinded, randomized controlled trial. Laryngoscope 2011; 121(12):2702-5.

Lee JM, Grewal A. Middle meatal spacers for the prevention of synechiae following endoscopic sinus surgery: a systematic review and meta-analysis of randomized controlled trials. Int Forum Allergy Rhinol 2012 [Epub ahead of print].

Marple BF, Smith TL, Han JK et al. Advance II: a prospective, randomized study assessing safety and efficacy of bioabsorbable steroid-releasing sinus implants. Otolaryngol. Head Neck Surg. 2012; 146(6):1004-11.

Murr AH, Smith TL, Hwang PH et al. Safety and efficacy of a novel bioabsorbable, steroid-eluting sinus stent. Int Forum Allergy Rhinol 2011; 1(1):23-32.

Forwith KD, Chandra RK, Yun PT et al. ADVANCE: a multisite trial of bioabsorbable steroid-eluting sinus implants. Laryngoscope 2011; 121(11):2473-80.

Catalona PJ, Thong M, Weiss R, Rimash T. The MicroFlow Spacer: a drug-eluting stent for the ethmoid sinus. Indian J Otolaryngol Head Neck Surg 2011; 63(3):279-84.

Rudmik L, Soler ZM, Orlandi RR et al. Early postoperative care following endoscopic sinus surgery: an evidence-based review with recommendations. Int Forum Allergy Rhinol 2011; 1(6):417-30.

Han JK, Marple BF, Smith TL. Effect of steroid-releasing sinus implants on postoperative medical and surgical interventions: an efficacy meta-analysis. Int Forum Allergy Rhinol 2012; 2(4):271-9.

Medical Director review 7/2012

Specialty Matched Consultant Advisory Panel – 8/2012

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.134, 6/13/13

Specialty Matched Consultant Advisory Panel - 8/2013

Medical Director review 8/2013

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.134, 11/14/13

Senior Medical Director review 4/2014

Specialty Matched Consultant Advisory Panel - 10/2014

Specialty Matched Consultant Advisory Panel - 8/2015

Specialty Matched Consultant Advisory Panel - 8/2016

American Academy of Otolaryngology-Head and Neck Surgery. Clinical Indicators: Endoscopic Sinus Surgery, Pediatric. 2012

Specialty Matched Consultant Advisory Panel - 8/2017

Medical Director review 5/2018

Han JK, Forwith KD, Smith TL, Kern RC, Brown WJ, Miller SK, Ow RA, Poetker DM, Karanfilov B, Matheny KE, Stambaugh J, Gawlicka AK. RESOLVE: a randomized, controlled, blinded study of bioabsorbable steroid-eluting sinus implants for in-office treatment of recurrent sinonasal polyposis. Int Forum Allergy Rhinol. 2014 Nov;4(11):861-70.

Forwith KD, Han JK, Stolovitzky JP, Yen DM, Chandra RK, Karanfilov B, Matheny KE, Stambaugh JW, Gawlicka AK. RESOLVE: bioabsorbable steroid-eluting sinus implants for in-office treatment of recurrent sinonasal polyposis after sinus surgery: 6-month outcomes from a randomized, controlled, blinded study. Int Forum Allergy Rhinol. 2016 Jun;6(6):573-81.

Kern RC, Stolovitzky JP, Silvers SL, Singh A, Lee JT, Yen DM, Iloreta AMC Jr, Langford FPJ, Karanfilov B, Matheny KE, Stambaugh JW, Gawlicka AK; RESOLVE II study investigators. A phase 3 trial of mometasone furoate sinus implants for chronic sinusitis with recurrent nasal polyps. Int Forum Allergy Rhinol. 2018 Apr;8(4):471-481.

Specialty Matched Consultant Advisory Panel - 8/2018

Sinuva Prescribing Information. Accessed 8/28/2018 at https://www.sinuva.com/wp-content/uploads/2018/03/sinuva-prescribing-information.pdf .

FDA approval. Accessed 8/28/2018 at https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2017/209310Orig1s000ltr.pdf .

Medical Director review 11/2018

Specialty Matched Consultant Advisory Panel – 9/2019

Medical Director review 7/2020

Specialty Matched Consultant Advisory Panel – 8/2020

Specialty Matched Consultant Advisory Panel – 8/2021

Specialty Matched Consultant Advisory Panel – 8/2022

Medical Director review -8/2023

Specialty Matched Consultant Advisory Panel – 8/2023

Patel ZM, Thamboo A, Rudmik L, et al. Surgical therapy vs continued medical therapy for medically refractory chronic rhinosinusitis: a systematic review and meta-analysis. Int Forum Allergy Rhinol. Feb 2017; 7(2): 119-127. PMID 27863163

Ragab SM, Lund VJ, Scadding G. Evaluation of the medical and surgical treatment of chronic rhinosinusitis: a prospective, randomized, controlled trial. Laryngoscope. May 2004; 114(5): 923-30. PMID 15126758

Medical Director review -8/2024

Specialty Matched Consultant Advisory Panel – 8/2024

Policy Implementation/Update Information

3/30/2010 New policy issued. BCBSNC will cover functional endoscopic sinus surgery (FESS) when determined to be medically necessary because the medical criteria and guidelines outlined in the policy are met. Notification given 3/30/10 for effective date 7/1/10. (adn)

7/6/2010 Specialty Matched Consultant Advisory Panel review 5/24/10. No change to policy statement or coverage criteria. (adn)

7/20/2010 Minor changes in *Description* section. In the *When FESS is covered* section: Revised Item 1.c. to read "For chronic rhinosinusitis, documentation of coronal CT and/or nasal endoscopy following optimal medical therapy showing persistent sinus pathology." Added item 1.d. which reads "For recurrent acute rhinosinusitis, coronal CT and nasal endoscopy may be normal after treatment. However, CT and/or nasal endoscopy during acute rhinosinusitis should document sinus pathology amenable to surgical treatment." Revised Item 2 to read "Multiple or recurrent polyps with airway obstruction and failure of optimal medical management (including assessment for allergy symptoms, and allergy evaluation if indicated) with persistent sinus disease on follow up CT scan and/or nasal endoscopy." Revised Item 4 to read "Chronic ~~anterior~~ headache or facial pain…" Inserted new items 6, 7 and 8 which read "6) Recurrent sinusitis with significant associated comorbid conditions (some examples include immune system disorders, and congenital or acquired ciliary dyskinesia), 7) Recurrent sinusitis which exacerbates significant comorbid conditions (including but not limited to asthma, recurrent bronchitis or pneumonia, diabetes), and 8) Multidrug resistant organisms identified by culture. Revised newly numbered Item 9 to

read "Sinonasal benign or malignant tumor (including inverted papilloma)." In the *Policy Guidelines* section, revised item 3.f. to read "antibiotic therapy consisting of three consecutive weeks of appropriate antibiotic drugs, OR multiple two to three week courses of appropriate antibiotic drugs during the symptomatic periods." CPT Codes 31237 and 31240 deleted from the *Billing/Coding* section. (adn)

9/13/11 Specialty Matched Consultant Advisory Panel review 8/31/11. No change to policy statement or medical criteria. (adn)

6/29/12 Code S1090 added to policy. "The use of a Propel sinus implant may be considered medically necessary when the following criteria are met. 1. Implanted at the time of approved functional endoscopic sinus surgery, and 2. Implanted in the ethmoid sinus only" added to the When Covered section. "Use of the Propel sinus implant is considered not medically necessary if inserted at any surgical setting other than the FESS procedure, or for any sinus cavities other than the ethmoid" added to the When Not Covered section. (sk)

7/24/12 Added information regarding implantable sinus stents/spacers for postoperative use following endoscopic sinus surgery to the Description section and to the Policy Guidelines section. Added "The use of implantable sinus stents/spacers for postoperative treatment following endoscopic sinus surgery is considered investigational. BCBSNC does not cover investigational services or supplies" to the When Not Covered section. References added. (sk)

11/13/12 Specialty Matched Consultant Advisory Panel review 8/15/12. Additional pediatric information added to Policy Guidelines. No change to policy statement. (sk)

11/12/13 Reference added. Existing references updated. Specialty Matched Consultant Advisory Panel review 8/21/13. Medical Director review. No change to policy statement. (sk)

2/25/14 Reference added. The word "spacer removed from its association with the word "stent" throughout the policy. No change to Policy intent. (sk)

7/15/14 Description section updated to include general information on drug-eluting sinus implants and specific information on the Propel™ sinus implant. Medical necessity criteria for use of a mometasone furoate sinus implant added to When Covered section. Not medically necessary criteria for use of a mometasone furoate sinus implant added to When Not Covered section. Policy Guidelines updated. (sk)

11/25/14 References added and updated. Specialty Matched Consultant Advisory Panel review 10/2014. Medical Director review. Policy title changed from Functional Endoscopic Sinus Surgery (FESS) to Surgical Treatment of Sinus Disease. Conditions in which Balloon Ostial Dilation would be considered not medically necessary added to the When Not Covered Section. Definition of optimal medical treatment added. Statement added that "Balloon ostial dilation as a standalone procedure in an ambulatory setting must be performed by a board eligible/board certified otolaryngologist who has admitting privileges at a local hospital." (sk)

10/1/15 Specialty Matched Consultant Advisory Panel review 8/26/15. (sk)

12/30/15 Codes 0406T and 0407T added to Billing/Coding section. (sk)

9/30/16 Specialty Matched Consultant Advisory Panel review 8/31/2016. Reference added and updated. (sk)

12/29/17 Reference added. Policy Guidelines updated with inclusion of pediatric criteria. Specialty Matched Consultant Advisory Panel review 8/30/2017. Codes 31241, 31253, 31257, 31259, and 31298 added to Billing/Coding section for effective date 1/1/2018. (sk)

5/25/18 Medical Director review. The following statement added to the Billing/Coding section for additional clarity: "Balloon sinuplasty (codes 31295, 31296, 31297) performed in conjunction with functional endoscopic sinus surgery (FESS) within the same sinus cavity, is considered incidental to the major service and not eligible for separate reimbursement." (sk)

11/30/18 Specialty Matched Consultant Advisory Panel review 8/22/2018. References added. Policy Guidelines updated. Information related to Sinuva™ mometasone furoate implant added to policy. Sinuva™ is considered investigational in the treatment of sinonasal polyposis. Code J3490 added to Billing/Coding section. Medical Director review. Notification given 11/30/2018 for effective date 1/29/2019. (sk)

10/01/19 Specialty Matched Consultant Advisory Panel review 9/20/2019. (sk)

6/30/20 New code C9122 added to Billing/Coding section. (sk)

7/14/20 Medical Director review. Criteria for balloon ostial dilation (BOD) moved to a separate medical policy. Silent sinus syndrome and antrochoanal polyps added to list of covered indication. (sk)

12/8/20 Specialty Matched Consultant Advisory Panel review 8/19/2020. Description section updated. Removed "Chronic headache or facial pain caused by a demonstrable anatomic or pathologic sinus disorder" from coverage criteria. Policy Guidelines updated. (sk)

3/31/21 New HCPCS codes J7402 and S1091 added to Billing/Coding section, effective 4/1/2021. Codes C9122, J3490, and S1090 deleted from Billing/Coding section, effective 4/1/2021. (sk)

12/14/21 Specialty Matched Consultant Advisory Panel review 8/18/2021. Added Fungal ball or mycetoma to list of covered indications. (sk)

2/7/23 Specialty Matched Consultant Advisory Panel review 8/19/2022. (sk)

9/29/23 Description updated. Removed terminated CPT codes 0406T and 0407T and added CPT codes 31237 and 31299. Added related policy. Changed patient to individual throughout policy. Updated references. Added Fungal Sinusitis to list of covered indications. When covered section updated as follows: added names of additional examples of mometasone furoate sinus implants. The use of a mometasone furoate sinus implant: Bullet 1 subsection to now read "individual is ≥ 18 years of age". Bullet 2 subsection to now read: "Ethmoid or frontal sinus surgery is planned". Policy guidelines updated in reference to oral antibiotic use. Medical Director review 8/2023. Specialty Matched Consultant Advisory Panel review 8/2023. (ldh)

9/18/24 Description and Regulatory Status updated. Added two related policies. Policy Guidelines updated. No change to policy intent. Medical Director review 8/2024. Specialty Matched Consultant Advisory Panel review 8/2024. (ldh)

and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.