


<b>MEDICAL POLICY</b>	<b>Balloon Dilation of the Sinuses or Eustachian Tubes (Medicare Only)</b>
<b>Effective Date: 12/1/2022</b>   12/1/2022	Medical Policy Number: 359  Medical Policy Committee Approved Date: 10/2022
Medical Officer                      Date	

**See Policy CPT/HCPCS CODE section below for any prior authorization requirements**

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Medicare Only

**MEDICARE POLICY CRITERIA**

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

**Note:** Balloon sinuplasty when performed in conjunction with functional endoscopic sinus surgery (FESS) or other more extensive sinus surgery of the same sinus, is considered an integral part of the procedure and is, therefore, not separately reimbursable.

Service	Medicare Guidelines
<i>Balloon Dilation of Sinuses or Eustachian Tubes</i>	Company medical policy for <a href="#">Balloon Dilation of the Sinuses or Eustachian Tubes (All Lines of Business Except Medicare)</a>  I. These services may be considered <b>medically necessary</b> for Medicare when the Company medical policy criteria are met. II. These services are considered <b>not medically necessary</b> for Medicare Plan members when the Company medical policy criteria are <b>not</b> met. <i>Services deemed “investigational” are considered not medically necessary for Medicare Plan members. See Policy Guidelines below.</i>

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**POLICY GUIDELINES**

Medicare and Medical Necessity

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare’s definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan’s use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.) which addresses the medical necessity of a given medical service, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. (*Medicare Managed Care Manual, Ch. 4, §90.5*)

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be “investigational.” The term “investigational” is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company’s technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are “not medically reasonable or necessary” for Medicare Plan members. (*Medicare Claims Processing Manual, Ch. 23, §30 A*)

**BILLING GUIDELINES**

General

Balloon sinuplasty when performed in conjunction with FESS or other more extensive sinus surgery of the same sinus, is considered an integral part of the procedure and is not separately reimbursable. This is not applicable to inferior turbinate resection as represented by the following CPT codes: 30140, 31254, 30117, 31240.

CPT codes 31231 and 31237 have a “separate procedure designation” and therefore, may not be billed when performed with another procedure in an anatomically related region through the same incision, orifice, or surgical approach.

The following codes are not appropriate to bill for balloon sinuplasty:

- 31231- Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

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- 31294- Nasal/sinus endoscopy, surgical; with optic nerve decompression

Code C9745 may only be billed by a facility.

**CPT/HCPCS CODES**

<b>Medicare Only</b>	
Prior Authorization Required	
<b>Balloon Sinus Ostial Dilation (Balloon Sinuplasty)</b>	
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)
<b>Balloon Dilation of Eustachian Tube(s) (BDET)</b>	
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral
<b>Unlisted Codes</b> All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then <b>prior-authorization is required.</b>	
69799	Unlisted procedure, middle ear

**INSTRUCTIONS FOR USE**

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

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**REGULATORY STATUS**

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.