

## Functional Endoscopic Sinus Surgery for Chronic Rhinosinusitis

**Policy # 00711**

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*Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

*Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.*

*Note: Balloon Catheter use for Sinus Ostial Dilatation and Septoplasty is addressed separately in medical policy 00292.*

*Note: Drug Eluting Sinus Stents and Implants for Postoperative Use Following Endoscopic Sinus Surgery and for Recurrent Sinonasal Polyposis is addressed separately in medical policy 00485.*

*Note: Balloon Dilation of the Eustachian Tube is addressed separately in medical policy 00613.*

### When Services May Be Eligible for Coverage

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider the use of functional endoscopic sinus surgery (FESS) for individuals with chronic rhinosinusitis to be **eligible for coverage\*\*** when **ALL** of the following criteria are met:

- Chronic rhinosinusitis symptoms persisted for a minimum of 12 weeks despite aggressive medical therapy; **AND**
- Documentation supports **ONE** of these requirements:
  - Aggressive medical therapy with **ALL** of the following:
    - Saline nasal irrigation for at least 8 consecutive weeks; **AND**
    - Intranasal corticosteroids for at least 8 weeks; **AND**
    - Two 10-day courses of antibiotics or one prolonged course of oral antibiotic for at least 21 days (*Note: In individuals with documented polyposis and absence of active infection, a trial of antibiotics may not be necessary.*); **OR**
  - Failure of 8 weeks of aggressive medical therapy is not required for **ANY** of the following:
    - Revision FESS requested for recirculating issues resulting in mucus stasis; **OR**

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- Revision FESS requested for chronic inflammation or infection; **OR**
  - Revision FESS requested for stenosis or obstruction of ostia; **OR**
  - Presence of serious urgent complications of acute sinusitis such as orbital cellulitis or abscess, intracranial extension of infection, or other complication that would require urgent or emergent surgery such that medical therapy for 8 weeks would not be appropriate; **AND**
- Chronic rhinosinusitis of the sinus to be operated on is confirmed with nasal endoscopy or anterior rhinoscopy, and computed tomography as evidenced by:
  - Purulent (not clear) mucus OR edema in the middle meatus, anterior ethmoid, or sphenoethmoid region; **AND**
  - Significant mucosal thickening of greater than 3 mm, opacification, or air-fluid levels documented by a formal CT scan report in the sinus to be operated on.

*Note: Chronic rhinosinusitis with polyposis (confirmed visualization of polyps on nasal endoscopy or anterior rhinoscopy) might require operation on multiple or all sinuses on the affected side.*

*Note: When assessing for response to therapy and potential surgical candidacy for individuals with chronic rhinosinusitis, CT scanning is typically performed approximately 1-2 weeks following completion of aggressive medical therapy and within 90 days of the planned procedure.*

## When Services Are Considered Not Medically Necessary

The use of functional endoscopic sinus surgery for the treatment of chronic rhinosinusitis when criteria are not met is considered to be **not medically necessary**.\*\*

## Policy Guidelines

Classification of rhinosinusitis is based upon symptom duration:

- Acute rhinosinusitis – Symptoms for less than 4 weeks
- Subacute rhinosinusitis – Symptoms for 4 to 12 weeks
- Chronic rhinosinusitis – Symptoms persist greater than 12 weeks
- Recurrent acute rhinosinusitis – Four or more documented and treated episodes of acute rhinosinusitis in a 12-month period, with interim symptom resolution

When indicated and appropriate, optimal medical therapy should include also:

- Allergy evaluation, education, and optimal treatment;
- Decongestants;
- Treatment of rhinitis medicamentosa (rebound nasal congestion due to extended use of topical decongestants); and
- Education on environmental irritants including tobacco smoke.

For individuals undergoing evaluation for surgical management of chronic sinusitis (either dilation or standard functional endoscopic sinus surgery), the CT scan on which the surgical plan and evaluation are based is typically performed within 90 days of the planned procedure. CT scans

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beyond 90 days may be repeated, as both disease and anatomy may have changed. CT scans older than 90 days may rarely be used in adult individuals when the symptoms and/or condition have not changed since the CT scan was obtained.

When assessing for response to therapy and potential surgical candidacy for individuals with chronic rhinosinusitis, CT scanning is typically indicated approximately 1-2 weeks following completion of aggressive medical therapy. Imaging prior to this time may underrepresent patient response and overrepresent disease burden. However, in certain circumstances, such as in lack of response to treatment or uncertainty of diagnosis, imaging may be indicated earlier in the treatment course or even prior to the initiation of treatment.

According to the 2025 American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS) guideline on adult sinusitis, abnormal findings on CT imaging may include moderate-to-severe mucosal thickening, opacification, or air-fluid levels. A subsequent consensus statement on balloon dilation of the sinuses published by the AAO-HNS in 2018 states: "The requirement of objective evidence of inflammation in addition to sinonasal symptoms suggestive of rhinosinusitis is consistent with AAO-HNSF diagnostic criteria for rhinosinusitis. However, evidence of inflammation or other findings on a CT scan was not deemed sufficient alone to make a patient a candidate for balloon dilation. The consensus that both symptoms and objective evidence of sinonasal disease are needed to deem a patient appropriate for a SOD [sinus ostial dilation] procedure is also reflected in many of the randomized clinical trials involving balloon dilation. The inclusion criteria for many of these trials require that the patient be deemed appropriate for conventional sinus surgery, which includes a trial of medical therapy and the presence of sinonasal symptoms in addition to objective evidence of sinus mucosal inflammation. On the surface, this statement may seem incompatible with the guidelines that mandate the presence of objective findings but do not specify which objective findings those are (ie, polyps, purulence, or CT findings) for the diagnosis of CRS. However, the panel felt that the transition from diagnosis to management requires additional information. In that vein, a CT scan is necessary before proceeding with surgical management, and the findings of that CT scan would direct which sinuses were to be addressed. It was also agreed that an improved taxonomy for the classification of sinusitis would be helpful to improve the quality of clinical research."

## **Background/Overview**

### **Chronic Rhinosinusitis**

Chronic rhinosinusitis (CRS) is a highly prevalent inflammatory disorder of the paranasal sinuses and the mucosa of the nasal passages that affects 3% to 7% of adults. In adults, CRS is characterized by symptoms related to nasal and sinus obstruction and inflammation, including mucopurulent nasal drainage, nasal congestion, facial pain or pressure, and anosmia or hyposmia, that persist for at least 12 weeks.

Three CRS subtypes exist and may have somewhat different treatment strategies: CRS without nasal polyposis; CRS with nasal polyposis; and allergic fungal sinusitis. The latter is a less common subtype thought to result from chronic allergic inflammation to colonizing nasal fungi. This medical

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policy focuses on the more common subtypes: CRS with and without nasal polyposis. Both subtypes present with similar symptoms. However, CRS with nasal polyposis is, by definition, associated with nasal polyps that are visible on rhinoscopy or nasal endoscopy. Further, CRS with nasal polyposis is more likely to be associated with asthma and aspirin intolerance; this triad is referred to as Samter syndrome or aspirin-exacerbated respiratory disease.

Chronic rhinosinusitis is associated with impaired quality of life for affected patients, and with high direct and indirect costs for medical treatments and lost productivity. Most often, the negative health effects of CRS are related to the unpleasant symptoms associated with CRS, including nasal congestion, nasal drainage, and facial pain or pressure. In rare cases, CRS can be associated with serious complications, including orbital cellulitis, osteomyelitis, or intracranial extension of infection.

While acute sinusitis is considered a more traditional infectious process, CRS is a chronic inflammatory disease of the upper airways, with multiple underlying causes. Risk factors for CRS with or without nasal polyps include anatomic variations and gastroesophageal reflux. There are conflicting reports about the association between allergy and CRS without nasal polyps, although weak evidence has suggested that allergy may be associated with CRS with nasal polyps. In addition, aspirin sensitivity may be associated with CRS with nasal polyps. The role of bacterial, viral, and fungal microorganisms in CRS has been actively investigated. There is some evidence that CRS is associated with a predominance of anaerobic bacteria. On the other hand, a study that used bacterial ribosomal RNA sequencing to evaluate the sinus microbiome in patients with and without CRS found a quantitative increase in bacterial and fungal RNA expression in patients with CRS, but no major differences in the types of microorganisms detected. Bacterial biofilms have been identified in cases of CRS.

### **Medical Therapy**

Medical therapy for CRS, with or without polyps, is often multimodal, including nasal irrigation, topical and/or systemic corticosteroids, monoclonal antibodies, and/or antibiotic therapy. Guidelines from the American Academy of Otolaryngology-Head and Neck Surgery (2015; affirmed in 2020 by the American Academy of Family Physicians) have recommended the use of saline nasal irrigation, topical intranasal corticosteroids, or both, for symptom relief of CRS, on the basis of systematic reviews of randomized controlled trials (RCTs). There is a specific recommendation against the use of topical and systemic antifungal therapies. The guidelines do not include a statement specifically addressing the use of systemic antibiotics for CRS; however, in the list of future research needs, the authors included: “Perform additional RCTs to clarify the impact of antibiotic therapy on CRS outcomes.”

A systematic review by Rudmik and Soler (2015) evaluated the evidence for various medical therapies for chronic sinusitis, excluding allergic fungal sinusitis. Reviewers included 29 studies, with 12 meta-analyses (with a total of >60 RCTs), 13 systematic reviews, and 4 individual RCTs not included in any meta-analyses. Topical corticosteroids were associated, in multiple studies, with improved symptom scores, reduced polyp size, and decreased polyp recurrence after surgery. Saline nasal irrigation was associated, in multiple studies, with significant improvements in symptom

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scores. There was some evidence that 2 systemic therapies (oral corticosteroids, doxycycline), both for 3 weeks, improved polyp scores in patients with CRS with nasal polyps. Long-term (>3 months) macrolide therapy was associated in an RCT with improved symptoms and quality of life in individuals with CRS without nasal polyps, although other studies did not find a benefit with chronic macrolide use.

In 2014, an evidence-based review summarized a series of earlier evidence-based reviews with recommendations related to CRS. This review concluded that both saline irrigation and topical corticosteroids are well-supported by the available published literature for treatment of CRS, with and without nasal polyps. For CRS with polyps, the evidence demonstrated short-term improvement in symptoms after short-term oral corticosteroid treatment. For CRS with or without nasal polyps, a small number of RCTs have shown improvement in nasal endoscopy scores and some symptoms with oral macrolide therapy. However, for CRS with or without nasal polyps, there was very limited evidence on the use of non-macrolide oral antibiotics.

A 2016 Cochrane review of studies evaluating systemic and topical antibiotics for CRS included 5 RCTs (N=293), all of which compared systemic antibiotics with placebo or another pharmacological intervention. Reviewers found "very little evidence that systemic antibiotics are effective in patients with chronic rhinosinusitis" and that "more research in this area, particularly evaluating longer-term outcomes and adverse effects, is required."

In 2019, the U.S. Food and Drug Administration (FDA) approved the first treatment for CRS with nasal polyps - dupilumab (Dupixent<sup>®†</sup>). Results from clinical trials revealed that patients who received dupilumab "had statistically significant reductions in their nasal polyp size and nasal congestion compared to the placebo group" and also "reported an increased ability to smell and required less nasal polyp surgery and oral steroids." This was followed by the approval of omalizumab (Xolair<sup>®</sup>) in 2020 as add-on maintenance treatment for adults with nasal polyps with an inadequate response to nasal corticosteroids. In 2021, mepolizumab (Nucala<sup>®†</sup>) was also approved as an add-on maintenance treatment in adults with CRS with nasal polyps.

### **Surgery**

The goals of surgery for CRS include removing polyps and debris that may be sources of inflammatory mediators and preventing the effective delivery of local medical therapies. In addition, to varying degrees, surgical techniques involve the creation of open sinus cavities, usually via dilation of the sinus ostia, to permit better drainage from the sinus cavities and more effective delivery of local therapies.

Techniques for functional endoscopic sinus surgery (FESS), in which an endoscope is used to access the sinus cavities and varying degrees of tissue are removed and the sinus ostia are opened, have evolved since the development of the nasal endoscope in the 1960s. Functional endoscopic sinus surgery has largely replaced various open techniques for CRS (eg, Caldwell-Luc procedure), although open procedures may have a role in complicated sinus pathologies (eg, endonasal tumors).

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Functional endoscopic sinus surgery encompasses a variety of degrees of sinus access and tissue removal and is described based on the sinuses accessed. The Draf classification is used to describe degrees of endoscopic frontal sinusotomy (Table 1).

**Table 1. Draf Classification for Endoscopic Frontal Sinusotomy**

| Type                  | Description                                                                                              |
|-----------------------|----------------------------------------------------------------------------------------------------------|
| Draf I                | Anterior ethmoidectomy without altering frontal sinus ostium                                             |
| Draf IIA              | Removal of ethmoid cells that extend into frontal sinus                                                  |
| Draf IIB              | Removal of frontal sinus floor between the middle turbinate and the lamina papyracea                     |
| Draf III <sup>a</sup> | Removal of frontal sinus floor from orbit to orbit with contiguous portions of the superior nasal septum |

<sup>a</sup> Modified Lothrop procedure.

This procedure can also be used to access the ethmoid sinuses, which may involve creation of drainage into the maxillary sinuses (maxillary antrostomy).

## **FDA or Other Governmental Regulatory Approval**

### **U.S. Food and Drug Administration (FDA)**

Functional endoscopic sinus surgery is a surgical procedure and, as such, is not subject to regulation by the FDA.

## **Rationale/Source**

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

### **Description**

Chronic rhinosinusitis (CRS) is a common chronic condition associated with significant morbidity. Functional endoscopic sinus surgery (FESS) involves the removal of varying amounts of tissue and the opening of sinus ostia to treat CRS.

### **Summary of Evidence**

For individuals with uncomplicated chronic rhinosinusitis (CRS) with or without nasal polyposis who receive functional endoscopic sinus surgery (FESS), the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, change in disease status, quality of life, and treatment-related morbidity. A small number of trials, with methodologic limitations, generally have not reported clinically significant differences

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in symptom improvement with FESS compared with medical therapy. Cochrane reviews evaluating FESS for CRS with and without nasal polyposis have reported that FESS can be accomplished safely, but clinical trials have not demonstrated significant improvements with FESS compared with standard medical therapy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

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.

## **Supplemental Information**

### **Practice Guidelines and Position Statements**

Guidelines or position statements will be considered for inclusion in ‘Supplemental Information’ if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Guidelines on the diagnosis and management of CRS are described in Tables 2 through 4.

**Table 2. Chronic Rhinosinusitis Diagnostic Criteria**

| <b>Organization</b>                                                               | <b>Chronic Rhinosinusitis Definition</b>                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| International Consensus Statement on Rhinology and Allergy: Rhinosinusitis (2021) | "Greater than or equal to 12 weeks of:<br>Two or more of the following symptoms: <ul style="list-style-type: none"><li>• Nasal discharge (rhinorrhea or post-nasal drip)</li><li>• Nasal obstruction or congestion</li><li>• Hyposmia</li><li>• Facial pressure or pain</li></ul> |

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| Organization                                                                 | Chronic Rhinosinusitis Definition                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              | <ul style="list-style-type: none"> <li>• Cough</li> </ul> AND<br>One or more of the following objective findings: <ul style="list-style-type: none"> <li>• Evidence of inflammation on nasal endoscopy or computed tomography</li> <li>• Evidence of purulence coming from paranasal sinuses or ostiomeatal complex</li> </ul> AND<br>CRS is divided into CRSsNP or CRSwNP based on the presence or absence of nasal polyps"                                                                                                                                                                                                                                                          |
| American Academy of Otolaryngology – Head and Neck Surgery Foundation (2025) | <p>“Twelve weeks or longer of 2 or more of the following signs and symptoms:</p> <ul style="list-style-type: none"> <li>• Mucopurulent drainage (anterior, posterior, or both),</li> <li>• Nasal obstruction (congestion)</li> <li>• Facial pain-pressure-fullness, or</li> <li>• Decreased sense of smell.</li> </ul> AND inflammation is documented by 1 or more of the following findings: <ul style="list-style-type: none"> <li>• purulent (not clear) mucus or edema in the middle meatus or anterior ethmoid region,</li> <li>• polyps in nasal cavity or the middle meatus, and/or</li> <li>• radiographic imaging showing inflammation of the paranasal sinuses.”</li> </ul> |

CRS: chronic rhinosinusitis; CRSsNP: chronic rhinosinusitis without nasal polyps; CRSwNP: chronic rhinosinusitis with nasal polyps; CT: computed tomography; MRI: magnetic resonance imaging.

Evaluation of patients for allergic disorders, immunodeficiencies, or both, may be indicated depending on the presence of associated symptoms.

**Table 3. American Academy of Otolaryngology-Head and Neck Surgery Guidelines on Management of CRS in Adults\***

| Guideline                                                                                                    | Type of Recommendation | Aggregate Evidence Quality  | Confidence in Evidence |
|--------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------|------------------------|
| Verify the diagnosis of CRS using diagnostic criteria (signs and symptoms) from clinical practice guidelines | Strong recommendation  | B (cross-sectional studies) | High                   |
| Assess candidacy for surgery based on symptoms, disease severity, QOL, and prior therapy                     | Strong recommendation  | B (cross-sectional studies) | High                   |

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| <b>Guideline</b>                                                                                                                                                                                                                                                                                               | <b>Type of Recommendation</b> | <b>Aggregate Evidence Quality</b>        | <b>Confidence in Evidence</b> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------|-------------------------------|
| The surgeon should not endorse or require a predefined, one-size-fits-all regimen or duration of medical therapy (eg, antibiotics, steroids, antihistamines) as a prerequisite to sinus surgery for an adult with CRS                                                                                          | Recommendation                | B (RCT and meta-analysis)                | High                          |
| The surgeon or their designee should not prescribe antibacterial therapy to an adult with CRS if significant or persistent purulent nasal discharge (anterior, posterior, or both) is absent on examination                                                                                                    | Strong recommendation         | B (RCT and meta-analysis)                | High                          |
| The surgeon should identify patients with CRS that would benefit most from surgery and are least likely to benefit from continued medical therapy alone, such as those with CRS subtypes that include, but are not limited to, CRS with polyps, polyps with bony erosion, eosinophilic mucin, or fungal balls. | Recommendation                | B (RCTs and large observational studies) | High                          |
| The surgeon or their designee should counsel patients before sinus surgery to establish realistic expectations, including the potential for chronicity or relapse, and the likelihood of long-term medical management, taking into account their CRS subtype                                                   | Recommendation                | B and C (Observational studies)          | Moderate                      |
| The surgeon should offer sinus surgery to an adult with CRS when the anticipated benefits exceed that of nonsurgical management alone, there is clarity regarding the anticipated outcomes, and the patient understands the expectation for long-term disease management following surgery.                    | Recommendation                | B and C (Observational studies)          | Moderate to High              |
| For an adult who is a candidate for sinus surgery, the surgeon or their designee should obtain a CT scan with a fine-cut protocol, if not already available, to examine the paranasal sinuses for surgical planning.                                                                                           | Recommendation                | B and C (Observational studies)          | High                          |
| The surgeon should not plan the extent of sinus surgery (eg, which specific sinuses to operate                                                                                                                                                                                                                 | Recommendation                | B (Systematic reviews,                   | Moderate                      |

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| Guideline                                                                                                                                                                                                                                                                                                                                                                                             | Type of Recommendation | Aggregate Evidence Quality                        | Confidence in Evidence |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------|------------------------|
| on) solely based on arbitrary criteria regarding a minimal level of mucosal thickening, sinus opacification, or outflow obstruction on a CT scan.                                                                                                                                                                                                                                                     |                        | cross-sectional studies, and logitudianl studies) |                        |
| The surgeon or their designee should educate an adult with CRS who is scheduled for sinus surgery regarding anticipated postoperative care, specifically pain control, debridement, medical management, activity restrictions, return to work, duration and frequency of follow-up visits,and the potential for recurrent disease or revision surgery.                                                | Recommendation         | B (RCT and systematic review)                     | Moderate               |
| When the sinus involves polyps, osteitis, bony erosion, or fungal disease in an adult with CRS who is scheduled forShin et al. S29sinus surgery, the surgeon should perform sinus surgery that includes full exposure of the sinus cavity (lumen) and removal of diseased tissue, not just balloon or manual ostialdilation, or refer the patient to a surgeon who can performthis extent of surgery. | Recommendation         | B and C (Observational studies)                   | Moderate               |
| The surgeon or their designee should routinely follow up to assess and document outcomes of sinus surgery for CRS, between 3 and 12 months after the procedure, through history (symptom relief, QOL, complications, adherence to therapy, need for rescue medications, and ongoing care) and nasal endoscopy.                                                                                        | Recommendation         | C (Longitudinal studies)                          | Low to Moderate        |

\* Adapted from Shin et al (20 25)

CRS: chronic rhinosinusitis; RCT: randomized controlled trial.

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**Table 4. Joint Task Force on Practice Parameters Guidelines for the Medical Management of CRS with Nasal Polyposis\***

| <b>Recommendation</b>                                                                  | <b>Strength of Recommendation</b> | <b>Certainty of Evidence</b> |
|----------------------------------------------------------------------------------------|-----------------------------------|------------------------------|
| Treatment with INCS is suggested (rather than no INCS) in people with CRSwNP           | Conditional                       | Low                          |
| Treatment with biologics is suggested (rather than no biologics) in people with CRSwNP | Conditional                       | Moderate                     |
| Treatment with ATAD is suggested (rather than no ATAD) in people with AERD             | Conditional                       | Moderate                     |

\*Adapted from Rank et al (2023)

AERD: aspirin (or nonsteroidal anti-inflammatory drug)-exacerbated respiratory disease; ATAD: aspirin therapy after desensitization; CRSwNP: chronic rhinosinusitis with nasal polyposis; INCS: intranasal corticosteroids.

#### **U.S. Preventive Services Task Force Recommendations**

Not applicable.

#### **Medicare National Coverage**

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

#### **Ongoing and Unpublished Clinical Trials**

No relevant ongoing or unpublished clinical trials were identified.

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### **Policy History**

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| 09/03/2020 | Medical Policy Committee review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 09/09/2020 | Medical Policy Implementation Committee approval. New policy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 10/06/2020 | Coding update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 03/04/2021 | Medical Policy Committee review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 03/10/2021 | Medical Policy Implementation Committee approval. Added a <i>Note</i> in the Patient Selection Criteria that “ <i>Chronic rhinosinusitis with polyposis (confirmed visualization of polyps on nasal endoscopy) might require operation on multiple or all sinuses.</i> ”                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 07/01/2021 | Medical Policy Committee review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 07/14/2021 | Medical Policy Implementation Committee approval. For the use of functional endoscopic sinus surgery for patients with chronic rhinosinusitis, added a forth open bullet to the Patient Selection Criteria as follows: <ul style="list-style-type: none"><li>○ For revision functional endoscopic sinus surgery requests, certain conditions and findings may not improve with medical therapy (i.e., recirculating issues resulting in mucus stasis, inflammation or infection, osteitis, or stenosis of ostia), therefore failure of 8 weeks of aggressive medical therapy is not required; AND</li></ul> Added anterior rhinoscopy as a procedure option to confirm chronic rhinosinusitis to the second Patient Selection Criteria bullet. Revised the <i>Note in the Patient Selection Criteria as follows: Chronic rhinosinusitis with polyposis (confirmed visualization of polyps on nasal endoscopy or anterior rhinoscopy) might require operation on multiple or all sinuses. In the absence of active infection, a trial of antibiotics may not be necessary in patients with documented polyposis.</i> |
| 07/07/2022 | Medical Policy Committee review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 07/13/2022 | Medical Policy Implementation Committee approval. Removed osteitis from the criteria bullet for the list of findings that may not improve with medical therapy for revision of functional endoscopic sinus surgery requests. Added classification of rhinosinusitis based upon symptom duration to the Policy Guidelines section. Coverage intent unchanged.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 07/06/2023 | Medical Policy Committee review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 07/12/2023 | Medical Policy Implementation Committee approval. Coverage eligibility unchanged.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 07/02/2024 | Medical Policy Committee review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

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07/10/2024 Medical Policy Implementation Committee approval. New paragraph added to the end of the Policy Guidelines section. Coverage eligibility unchanged.

07/03/2025 Medical Policy Committee review

07/09/2025 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

07/02/2026 Medical Policy Committee review

07/08/2026 Medical Policy Implementation Committee review

07/16/2026 Medical Quality Management Committee approval. Changed the use of functional endoscopic sinus surgery for the treatment of chronic rhinosinusitis from investigational to not medically necessary.

Next Scheduled Review Date: 07/2027

### **Coding**

*The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)†, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.*

*The responsibility for the content of Louisiana Blue Medical Policy Coverage Guidelines is with Louisiana Blue and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Louisiana Blue Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Louisiana Blue Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.*

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

| Code Type        | Code                                                                 |
|------------------|----------------------------------------------------------------------|
| CPT              | 31253, 31254, 31255, 31256, 31257, 31259, 31267, 31276, 31287, 31288 |
| HCPCS            | No codes                                                             |
| ICD-10 Diagnosis | J32.0-J32.9                                                          |

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**\*\*Medically Necessary (or “Medical Necessity”)** - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

**NOTICE:** If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

**NOTICE:** Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

**NOTICE:** Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

**NOTICE:** If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan’s authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan’s pharmacy benefit.