Priority Health	BILLING POLICY No. 119
Balloon Sinus Ostial Dilation for Chronic Sinusitis and Eustachian Tube Dilation	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITIONS:

Balloon sinus ostial dilation (BSOD): A technique in which a small balloon-like device is placed within the sinus passage or sinus ostia. The balloon is then inflated to move aside tissue and bone to create a larger airway passage and to allow for drainage of nasal secretions.

Chronic sinusitis: Prolonged or recurrent infection and inflammation of the nasal sinuses.

Eustachian tube balloon dilation (ETBD): A technique in which a small balloon-like device is placed into the eustachian tube and inflated to remodel the cartilage of the passageway.

Eustachian tube dysfunction (ETD): A physiological disorder of the eustachian tube that results in the inability to appropriately equalize pressure between the middle ear and environment.

Functional endoscopic sinus surgery (FESS): Surgical procedure used to treat chronic sinusitis and other conditions of the sinus.

MEDICAL POLICY

Balloon Sinus Ostial Dilation for Chronic Sinusitis and Eustachian Tube Dilation - 91596

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

For treatment of chronic sinusitis, documentation must include:

- Documentation of persistent rhinosinusitis for greater than three months
- Documented failure of greater than three months of medical therapy demonstrated by persistent upper respiratory symptoms despite therapy. Therapy must consist of a minimum of two different antibiotics with a trial of steroid spray, antihistamine spray, and/or decongestant.
- Radiological evidence of at least ONE of the following:
  - Air fluid levels
  - Mucosal thickening greater than 2mm
  - Opacification

- Nasal polyposis

For treatment of Eustachian tube dysfunction, documentation must include:

- Adults 18 or older
- Any of the following for at least 6 months
  - Aural fullness (sensation of clogged ears)
  - Aural pressure or otalgia
  - Hearing loss
  - Autophony
- History of chronic ear disease or intolerance to barometric changes greater than six months
- Tympanic membrane abnormality on exam
- Complete nasal endoscopy assessing the eustachian tube lumen confirming transnasal access to the nasopharynx and elimination extrinsic causes of ETD
- Failure, intolerance, or contraindication to appropriate management of co-occurring conditions
- Tympanometry of intact tympanic membrane showing Type A, B, or C tympanogram
- History of prior tympanostomy tube placement demonstrating relief from symptoms while tubes present

When undergoing both BSOD and EDBT at the same time both sets of criteria must be met.
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Reimbursement specifics

Balloon sinus ostial dilation used during functional endoscopic sinus surgery (FESS) is considered integral to the primary FESS procedure and is not separately reimbursable.
Diagnostic endoscopy service should not be performed on the same side on the same date of service (Codes 31231, 31233, & 31235)

Coding specifics

31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium, transnasal or via canine fossa
31296	Nasal/sinus endocopy, surgical; with dilation of frontal sinus ostium
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium
31298	Nasal/sinus endoscopy, surgical; eith dilation of frontal and sphenoid sinus ostia
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube; unilateral
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube; bilateral
C2625	Stent, noncoronary, temporary, with delivery system (Not covered with Propel system)
J4702*	Mometasone furoate sinus implant, 10mcg

*Covered for Medicare only

Non covered codes

S1091	Stent, noncoronary, temporary, with delivery system (Propel)

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

https://www.entnet.org/resource/cpt-for-ent-balloon-sinus-dilation-2/
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2180CP.pdf

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made