

Functional Endoscopic Sinus Surgery (FESS)

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[Instructions for Use](#)

Table of Contents	Page
Coverage Rationale	1
Documentation Requirements	2
Definitions	2
Applicable Codes	3
Description of Services	3
Clinical Evidence	4
U.S. Food and Drug Administration	8
Centers for Medicare and Medicaid Services	8
References	8
Policy History/Revision Information	9
Instructions for Use	10

Related Commercial Policy
<ul style="list-style-type: none"> Balloon Sinus Ostial Dilation
Community Plan Policy
<ul style="list-style-type: none"> Functional Endoscopic Sinus Surgery (FESS)

Coverage Rationale

Functional Endoscopic Sinus Surgery (FESS) is proven and medically necessary when one or more of the following conditions are present:

- [Chronic Rhinosinusitis](#) with or without polyps which has all of the following:
 - Lasted longer than 12 weeks
 - Persistence of symptoms despite administration of full courses of all of the following treatments:
 - Antibiotic therapy, if bacterial infection is suspected, and
 - Intranasal corticosteroids, and
 - Nasal lavage
 - Confirmation of [Chronic Rhinosinusitis](#) on a computed tomography (CT) scan for each sinus to be treated meeting all of the following criteria:
 - CT images are obtained after completion of [medical management](#), and
 - Scoring of CT images is done by using the [Modified Lund-Mackay Scoring System](#), and
 - CT findings include one or more of the following:
 - Bony remodeling
 - Bony thickening
 - Opacified sinus
 - Ostial obstruction (outflow tract obstruction) and mucosal thickening
 - Sinonasal symptoms such as pain, pressure, or drainage are present on the same side as CT scan findings of rhinosinusitis
- [Recurrent Acute Rhinosinusitis](#) with all of the following:
 - Four or more episodes per year with distinct symptom free intervals between episodes, and
 - CT scan evidence of ostial obstruction (outflow tract obstruction) and mucosal thickening in the sinus to be treated, and
 - Sinonasal symptoms such as pain, pressure, or drainage are present on the same side as CT scan findings of rhinosinusitis

- Any of the following conditions confirmed on CT scan:
 - Complications of sinusitis such as abscess
 - Concha bullosa
 - Mucocele
 - Polyposis with obstructive symptoms (for Chronic Rhinosinusitis with polyps see the [above criteria](#))
 - Sinonasal tumor

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Functional Endoscopic Sinus Surgery (FESS)	
31240 31253 31254 31255 31256 31257 31259 31267 31276 31287 31288	<p>Medical notes documenting the following:</p> <ul style="list-style-type: none"> • Chronic Rhinosinusitis (CRS) with the following: <ul style="list-style-type: none"> ○ Signs and symptoms ○ Treatments tried and failed including duration of treatments/medical therapies ○ Post medical management CT scan images: <ul style="list-style-type: none"> ▪ That show the abnormality for which surgery is being requested ▪ Are the optimal image to show the abnormality of the affected area with use of the Modified Lund-Mackay Scoring System to define the severity of Chronic Rhinosinusitis ▪ Note: CT images are required and must be labeled with: <ul style="list-style-type: none"> - The date taken - The applicable case number obtained at time of notification, or member's name and ID number on the images - Whether the imaging was taken pre-or post-medical therapy ▪ CT images can be submitted via the external portal at www.uhcprovider.com/paan or via email at CCR@uhc.com; faxes will not be accepted ○ CT scan report quantifying the severity of Chronic Rhinosinusitis using the Modified Lund-Mackay Scoring System (for each side for which treatment is being requested) • Recurrent Acute Rhinosinusitis with the following: <ul style="list-style-type: none"> ○ Number of episodes per year of Acute Rhinosinusitis ○ Signs and symptoms ○ CT scan images: <ul style="list-style-type: none"> ▪ That show the abnormality for which surgery is being requested ▪ Are the optimal image to show the abnormality of the affected area ▪ Note: CT images are required and must be labeled with: <ul style="list-style-type: none"> - The date taken - The applicable case number obtained at time of notification, or member's name and ID number on the images - Whether the images were taken pre- or post-medical therapy ▪ CT images can be submitted via the external portal at www.uhcprovider.com/paan or via email at CCR@uhc.com; faxes will not be accepted • CT scan report quantifying the severity of Acute Rhinosinusitis using the Modified Lund-Mackay Scoring System (for each side for which treatment is being requested)

*For code descriptions, see the [Applicable Codes](#) section.

Definitions

Acute Rhinosinusitis (ARS): ARS is a clinical condition characterized by inflammation of the mucosa of the nose and paranasal sinuses with associated sudden onset of symptoms of purulent nasal drainage accompanied by nasal obstruction, facial

pain/pressure/fullness, or both of up to 4 weeks duration (American Academy of Otolaryngology-Head and Neck Surgery [AAO-HNS] Clinical indicators for endoscopic sinus surgery for adults. 2012, Updated 2015).

Chronic Rhinosinusitis (CRS): CRS is one of the more prevalent chronic illnesses in the United States and is an inflammatory process that involves the paranasal sinuses and persists for longer than 12 weeks (Rosenfeld et al., 2015; Peters et al., 2014).

Functional Endoscopic Sinus Surgery (FESS): FESS is a minimally invasive, mucosal-sparing surgical technique utilized to treat medically refractory CRS with or without polyps or recurrent acute rhinosinusitis.

Modified Lund-Mackay Scoring System: A tool used to quantify the severity of Chronic Rhinosinusitis based on computed tomography (CT) scan findings. The Lund-Mackay System was modified by Zinreich by increasing the scale from 0 to 5. In the modified Lund-Mackay System, each sinus is assigned a score based on the percentage of opacification from mucosal thickening as follows: 0 = 0%, 1 = 1% to 25%, 2 = 26% to 50%, 3 = 51% to 75%, 4 = 76% to 99%, and 5 = 100% or completely occluded. The ostiomeatal complex is given a score of 0 to 2, depending on whether it is completely patent, partially obstructed, or completely obstructed. Each side is graded and their sum is the total score out of maximum of 54 (Likness et al., 2014).

Recurrent Acute Rhinosinusitis (RARS): RARS has been defined as four episodes per year of acute rhinosinusitis with distinct symptom free intervals between episodes (Rosenfeld et al., 2015).

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus

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Description of Services

Functional Endoscopic Sinus Surgery (FESS) is a set of minimally invasive surgical techniques which allow direct visual examination and opening of the sinuses for the treatment of Chronic Rhinosinusitis (CRS) which has not responded to medical

treatment. The use of FESS allows for a much less invasive and traumatic procedure, resulting in shorter surgery and healing times, less postoperative discomfort, and fewer surgical complications.

Rhinosinusitis, also referred to as sinusitis, is inflammation of the mucosal membrane lining the nasal cavities and the paranasal sinuses. Rhinosinusitis lasting more than 12 weeks is classified as CRS (Rosenfeld et al. 2015; Peters et al. 2014).

The goals of treating CRS are to eliminate underlying causes, reduce sinus inflammation, and drain nasal passages. Medical therapy is the first-line treatment for CRS. Treatments recommended may include nasal saline sprays, nasal lavage, antibiotic therapy, nasal corticosteroids, oral or injected corticosteroids, decongestants, over-the-counter pain relievers, leukotriene modifiers, and antihistamines. Patients who do not respond to medical therapy are candidates for sinus surgery (Marple et al. 2011).

Clinical Evidence

Functional Endoscopic Sinus Surgery (FESS)

Ni et al. (2018) conducted a systematic review and meta-analysis on studies using the Sinus and Nasal Quality of Life Survey (SN-5) which is a validated symptom questionnaire in pediatric chronic rhinosinusitis (CRS). A total of 10 studies, consisting of 13 separate treatment arms of either medical therapy, adenoidectomy, balloon catheter sinuplasty (BCS), or FESS were included in the review. The investigators limited inclusion of studies to pre/post studies that reported changes in SN-5 scores. Despite the multiple interventions under consideration in this meta-analysis, no treatment comparisons were conducted. Two of the 10 studies that met inclusion criteria for the meta-analysis reported SN-5 improvement following treatment with FESS. In the FESS-stratified meta-analysis of these 2 studies that included 22 total patients, the mean SN-5 score decreased by 1.83 points (95% CI, 1.47 to 2.19), which the authors report as a statistically significant improvement ($P < 0.00001$).

The National Cancer Database was queried for cases of sinonasal squamous cell carcinoma (SNSCC) without cervical or distant metastases that were treated surgically between 2010 and 2014. They were divided into 2 groups based on surgical approach: open or endoscopic. Cox proportional hazard analysis was performed. Propensity score matching (PSM) was used to mimic a randomized, controlled trial. A total of 1,483 patients were identified: 353 (23.8%) received endoscopic and 1130 (76.2%) received open surgery. Age, gender, race, geographic region, tumor size, surgical margins, postoperative chemoradiation, and 30-day readmissions did not vary significantly between the 2 groups. Open surgery was more common in academic centers (62.8% vs 54.2%; $p = 0.004$), less common for tumors of the ethmoid and sphenoid sinus ($p < 0.0001$), less common for stage IVB tumors, and associated with longer hospital stay. Five-year overall survival (OS) (5Y-OS) was not significantly different between the 2 approaches ($p = 0.953$; open: 5Y-OS, 56.5%; 95% confidence interval, 51.3% to 61.6%; endoscopic: 5Y-OS, 46.0%; 95% confidence interval, 33.2% to 58.8%). In the PSM cohort of 652 patients, there was also no significant difference in OS ($p = 0.850$). The investigators concluded that endoscopic surgery is an effective alternative to open surgery, even after accounting for confounding factors that may favor its use over the open approach (Kılıç et al., 2018).

Kim and Kwon (2017) conducted a meta-analysis to evaluate recurrence of sinonasal inverted papilloma (IP) based on the type of surgical approach. Fourteen retrospective cohort studies involving a total of 696 endoscopic approaches and 444 nonendoscopic approaches were included in the review. The pooled risk ratio (RR) for IP recurrence (endoscopic vs. external approach) was 0.56 [95% CI: 0.36-0.85, $I^2 = 48.3\%$]. A subgroup analysis was also performed. The investigators concluded that surgical management of IP via an endoscopic approach reduces the risk of recurrence compared to an external approach. Although further data are needed, early-stage IP requires endoscopic or endoscopic-assisted surgery to reduce the risk of tumor recurrence.

In a systematic review and meta-analysis, Patel et al. (2017) examined the literature regarding management of CRS patients refractory to appropriate medical therapy (AMT). Adult CRS patients who received AMT and then underwent either medical or surgical therapy in moderate to high level prospective studies were included. Six observational or before/after studies were included in the systematic review with 5 included in the meta-analysis. On meta-analysis, for CRS patients refractory to AMT, endoscopic sinus surgery (ESS) significantly improves objective endoscopic scoring outcomes vs continued medical therapy alone. In patients with refractory CRS who had significant reductions in baseline quality of life (QOL), ESS results in significant improvements. Continued medical therapy appears to maintain outcomes in patients with less severe baseline QOL. Unpooled analysis demonstrated improvement in health utility and olfaction following ESS compared to continued medical therapy alone, in medically refractory CRS.

Wood et al. (2017) conducted a prospective study to prospectively assess treatment outcomes of CRS patients undergoing FESS and post-operative medical treatment over a prolonged follow-up period. The study included 200 non-consecutive patients in the tertiary referral practice of a single surgeon. Symptoms were scored by patients pre-operatively and over a minimum follow-up period of 12 months. The median pre-operative symptom score was 16 (out of a maximum of 25). Symptom scores reduced to a median of 7 after 12 months of follow up. The median symptom score improved for all symptoms and across all patient subgroups. The authors concluded that extensive FESS offers significant and durable symptom improvement in patients with CRS refractory to medical treatment and prolonged medical therapy is recommended after FESS.

Djukic et al. (2015) evaluated the clinical outcomes and quality of life (QoL) in patients with NP after FESS. The prospective study included 85 consecutive adult patients (≥ 18 years) with nasal polyposis (NP) who were operated on using FESS after failure of the medical treatment and in certain cases of surgical treatment. The objective finding was presented as endoscopic and computerized tomography (CT) score. The intensity of each symptom, the values of symptom scores (major, minor and total), the values of dimension scales and summary scales of the QoL, as well as the values of endoscopic score through three periods of time (pre-surgery, 6 and 12 months after the surgery) were analyzed. Following FESS, mean intensity values of all individual symptoms and symptom scores were significantly lower and the values of all dimension scales and summary scales of QoL were significantly higher ($p < 0.05$). There was no statistically significant difference in symptom intensity and QoL after 6 and 12 months of surgical treatment ($p > 0.05$). Endoscopic score was on average significantly lower after 6 and 12 months of FESS ($p < 0.05$), but the mean score value after 12 months of operation was significantly higher in relation to that after 6 months of surgery ($p < 0.05$). Nevertheless, the recurrence of NP was observed in 28 patients (32.9 %) in the follow-up period. In conclusion, FESS in NP patients results in significant improvement of symptom intensity, QoL and endoscopic score. While the intensity of symptoms and QoL showed a tendency to maintain between 6 and 12 months after surgery, endoscopic score showed a tendency of exacerbation in the same period.

In a systematic review, Vlastarakos et al. (2013) evaluated the quality of evidence in the use of FESS for the treatment of CRS in children, regarding the respective changes in their QOL and the outcome that follows the operation. Fifteen studies were systematically analyzed. Four represented Level II, 5 Level III, and 6 Level IV evidence. The total number of treated patients was 1301. Thirteen research groups reported that pediatric FESS is an effective treatment for CRS; the respective positive outcome ranged between 71 and 100% of operated children. Five studies concluded that this treatment modality is associated with significant improvement in the children's postoperative QOL. Systemic diseases and environmental factors may have unfavorable prognostic effects; cystic fibrosis is associated with at least 50% recurrence rate. The rate of major complications following pediatric FESS is 0.6%, and the respective rate of minor complications is 2%. The authors concluded that surgical management with FESS in children with CRS is effective when optimal medical treatment proves unsuccessful (grade B strength of recommendation), and is associated with improvement in the children's QOL (grade B strength of recommendation). FESS also improves the sinusitis-associated symptoms and QOL in children with cystic fibrosis (grade C strength of recommendation). According to the authors, most complications of pediatric FESS reported in the literature are minor, and associated with difficulties in the postoperative assessment and care of pediatric patients.

Scangas et al. (2013) conducted a retrospective data analysis at a university tertiary referral center to characterize the natural history, clinical characteristics, management principles, and outcomes of paranasal sinus mucocoeles. A chart review was performed on 102 patients with a total of 133 paranasal sinus mucocoeles. Patients were diagnosed with a mucocoele on average 5.3 years following prior FESS, 17.7 years following prior paranasal sinus trauma, and 18.1 years following prior open sinus surgery. The most common presenting symptoms were headache (42.1%) and maxillofacial pressure (28.6%). The most common sites were the frontal, frontoethmoidal, and ethmoid sinuses. Fifty-seven mucocoeles (44.9%) had intraorbital extension, intracranial extension, or both. Out of 133 mucocoeles, 114 underwent ESS without complication. The authors concluded that the endoscopic approach can be safely used for the management of mucocoeles.

Higgins et al. (2011) conducted a systematic review with a pooled-data analysis to compare outcomes of endoscopic versus craniofacial resection of sinonasal malignancies. The review included 15 case series with individual data on 226 patients. The overall 5-year survival rate for the sample was 56.5%. Because of the paucity of data with endoscopic resection of high-stage malignancies, the outcome results were highly variable and no useful comparison could be made. Among low-stage malignancies (T1-2 or Kadish A-B), the endoscopic and open approaches demonstrated no statistically significant difference in outcome results. The 5-year overall survival was 87.4% in the endoscopic group versus 76.8% for open approaches; disease-specific survival was 94.7% versus 87.7%; and locoregional control rate was 89.5% versus 77.2%. The authors concluded that

transnasal endoscopic resection appears to be a reasonable alternative to craniofacial resection in the management of low-stage sinonasal malignancies.

In a prospective, multi-institutional cohort study, Smith et al. (2010) measured the proportion of patients with CRS who experienced clinically significant improvement after ESS and identified preoperative characteristics that predict clinically significant improvement in quality of life (QOL) after ESS. A total of 302 patients with CRS from three centers were enrolled in the study and followed for an average of 17.4 months postoperatively. Preoperative patient characteristics, CT scan, endoscopy score, and pre- and postoperative quality of life (QOL) data were collected. Univariate and multivariate analyses were performed. Patients improved an average of 15.8 percent (18.9 points) on the Rhinosinusitis Disability Index and 21.2 percent (21.2 points) on the Chronic Sinusitis Survey (both $P < 0.001$). Patients significantly improved on all eight Medical Outcomes Study Short Form-36 (SF-36) subscales (all $P < 0.001$). Among patients with poor baseline QOL, 71.7 percent of patients experienced clinically significant improvement on the RSDI and 76.1 percent on the CSS. Patients undergoing primary surgery were 2.1 times more likely to improve on the RSDI (95% confidence interval [CI], 1.2, 3.4; $P = 0.006$) and 1.8 times more likely to improve on the CSS (95% CI, 1.1, 3.1; $P = 0.020$) compared with patients undergoing revision surgery. In this prospective, multi-institutional study, most patients experienced clinically significant improvement across multiple QOL outcomes after ESS. Specific patient characteristics provided prognostic value with regard to outcomes.

Toros et al. (2007) compared the outcomes of endoscopic sinus surgery in patients with chronic sinusitis without nasal polyps (CRS) and those with nasal polyps (NP). The investigators also determined the correlation between preoperative CT findings and postoperative endoscopy and symptom score improvement. Data were collected from two groups of patients diagnosed as CRS with and without nasal polyps that underwent functional endoscopic sinus surgery with a 1-year postoperative follow up. Preoperative symptoms, CT scores, and endoscopic scores were recorded. Assessment of symptoms was performed subjectively using visual analogue scoring (VAS). CT scan findings were scored using the Lund-Mackay system. The correlations between the CT score, endoscopic scores and VAS scores were calculated. There was a statistically significant correlation between the preoperative CT, symptom, and endoscopic scores. Postoperative symptom and endoscopic scores also showed a significant correlation. Total CT scores of the CRS group were significantly lower than the scores of the NP group. Also preoperative endoscopy and symptom scores were statistically lower in CRS group compared to NP group. Endoscopy total scores and symptom total scores of both groups were significantly decreased at postoperative 12th month. Statistically significant difference was observed between the preoperative and postoperative symptom and endoscopy scores. The patients with polyps had higher symptom scores and worse objective findings compared to the patients with CRS. In all patients groups, objective and subjective scores seemed to correlate well preoperatively and postoperatively. These data suggest that endoscopic sinus surgery provides significant symptomatic relief and endoscopic healing in patients with CRS and NP.

Maru and Gupta (1999) conducted a study of 150 patients with chronic sinusitis, who underwent CT scan of the paranasal sinuses prior to FESS. The CT Scans were evaluated to detect the incidence of concha bullosa and its types, the significance of concha bullosa in the formation of ostiomeatal complex disease and the relation between type of concha bullosa and ostiomeatal complex disease. All patients underwent FESS. According to the investigators, functional endoscopic sinus surgery is the technique of choice for management of inflammatory disease of middle meatus and concha bullosa so as to restore the normal function of the middle turbinate.

Modified Lund-Mackay Scoring System

In a prospective multicenter study, Likness et al. (2014) evaluated CT scans of CRS patients using a novel objective 3D computerized system and compared results with a novel 2D computerized analysis of a single coronal slice through the osteomeatal complex (OMC) and subjective methods including Lund-Mackay and Zinreich's modified Lund-Mackay. Forty-six adults with a diagnosis of CRS underwent CT examination and received an intramuscular triamcinolone injection, dosage weight dependent, followed by CT scan 4 to 5 weeks later. Recruitment lasted 21 months. Scans were evaluated with all 4 scoring methods over 5 months. The Lin's concordance class correlation (CCC) of the OMC method revealed the best correlation to the 3D volumetric computerized values (0.915), followed by the Zinreich (0.904) and Lund-Mackay methods (0.824). Posttreatment results demonstrated that both the OMC (0.824) and Zinreich's (0.778) methods had strong agreement with the 3D volumetric methods and were very sensitive to change, whereas the Lund-Mackay (0.545) had only moderate agreement. The authors concluded that computerized CT analysis provides the most comprehensive, objective, and reproducible method of measuring disease severity and is very sensitive to change induced by treatment intervention. The authors stated that a 2D coronal image through the OMC provides a valid, user-friendly method of assessing CRS and is

representative of CRS severity in all sinuses. According to the authors, Zinreich's subjective method correlated well overall, but the Lund-Mackay method lagged behind in disease representation and sensitivity to change.

Professional Societies

American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)

The AAO-HNS developed a clinical consensus statement on the use of sinus ostial dilation (SOD) of the paranasal sinuses. An expert panel of otolaryngologists was assembled to represent general otolaryngology and relevant subspecialty societies. A modified Delphi method was used to distill expert opinion into clinical statements that met a standardized definition of consensus. Consensus was reached that there is a role for treating patients with recurrent acute sinusitis as defined in the AAO-HNSF guideline based on symptoms and the CT evidence of ostial occlusion and mucosal thickening (Piccirillo et al., 2018).

In a 2015 Clinical Practice Guideline (update) for Adult Sinusitis, the AAO-HNS indicates that clinicians should recommend saline nasal irrigation, topical intranasal corticosteroids, or both for symptom relief of chronic rhinosinusitis (CRS). Computed tomography (CT) of the paranasal sinuses should be obtained when endoscopic sinus surgery is considered or planned in patients with CRS or recurrent acute rhinosinusitis (ARS). In addition to demonstrating abnormal mucosa and opacified sinuses, CT will provide the anatomic detail necessary to guide the surgery. Surgical management of CRS is not discussed “because of insufficient evidence (e.g., RCTs) for evidence-based recommendations” (Rosenfeld et al. 2015).

The AAO-HNS clinical indicators for endoscopic sinus surgery for adults state that the indications for endoscopic sinus surgery include a history of one of more of the following:

- CRS with or without nasal polyps with persistent symptoms and objective evidence of disease by endoscopic and/or CT imaging that is refractory to medical treatment
- Allergic fungal rhinosinusitis
- Unilateral paranasal sinus opacification, symptomatic or asymptomatic, consistent with CRS with or without nasal polyps, fungus ball, or benign neoplasm (i.e., inverted papilloma)
- Complications of sinusitis, including extension to adjacent structures such as orbit or skull base
- Sinonasal polyposis with nasal airway obstruction or suboptimal asthma control
- Mucocele
- Recurrent acute rhinosinusitis

The AAO-HNS clinical indicators for endoscopic sinus surgery also indicate that imaging studies should generally be obtained after optimal medical therapy (American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) Clinical indicators for endoscopic sinus surgery for adults. 2012, Updated 2015).

American Academy of Allergy Asthma and Immunology (AAAA), the American College of Allergy Asthma and Immunology (ACAAI), and the Joint Council of Allergy Asthma and Immunology (JCAAI)

In a practice parameter for the diagnosis and management of rhinosinusitis, the AAAA, ACAAI, and JCAAI recommends that although medical therapy is the mainstay of disease management, FESS should be considered when medical therapy fails. According to the AAAA, ACAAI, and JCAAI, indications for surgical intervention include the following (Peters et al. 2014):

- When nasal polyps obstruct sinus drainage and persist despite appropriate medical treatment
- When there is recurrent or persistent infectious rhinosinusitis despite adequate trials of medical management that at least includes topical nasal steroids and nasal irrigations
- For biopsy of sinonasal tissue to rule out granulomatous disease, neoplasm, ciliary dyskinesia, or fungal infections
- When maxillary antral puncture is required (as for culture-directed therapy)
- When anatomic defects obstruct the sinus outflow tract, particularly the ostiomeatal complex (and adenoidal tissues in children)
- For rhinosinusitis with threatened complications (such as threat of brain abscess, meningitis, cavernous sinus thrombosis, or frontal bone osteomyelitis)

Regarding medical management for CRS, the AAAA, ACAAI, and JCAAI indicate that the role of antibiotics in CRS is controversial. For CRS associated with suspected bacterial infection, a longer duration of therapy beyond the usual 10 to 14 days is suggested; the choice of appropriate antibiotic therapy may need to consider the possible presence of anaerobic

pathogens. Because CRS is an inflammatory disease, intranasal corticosteroids (INs) are indicated for treatment. Other adjunctive therapy, such as intranasal antihistamines, decongestants, saline irrigation, mucolytics, and expectorants, might provide symptomatic benefit in select cases (Peters et al. 2014).

American College of Radiology (ACR)

The ACR Appropriateness Criteria for Sinonasal Disease (ACR 2017) indicates the following:

- Most cases of uncomplicated acute and subacute rhinosinusitis are diagnosed clinically and should not require any imaging procedure.
- CT of the sinuses without contrast is the imaging method of choice in patients with recurrent acute sinusitis or chronic sinusitis, or to define sinus anatomy prior to surgery.
- Immunocompromised patients are at high risk for invasive fungal sinusitis.
- In patients with suspected sinonasal mass or suspected orbital and/or intracranial complication of sinusitis, MRI and CT are complementary studies.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

FESS is a procedure and, therefore, not subject to FDA regulation. However, any medical devices, drugs, biologics, or tests used as a part of this procedure may be subject to FDA regulation.

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) for Functional Endoscopic Sinus Surgery (FESS). Currently, Local Coverage Determinations (LCDs) do not exist. (Accessed May 11, 2020)

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Policy History/Revision Information

Date	Summary of Changes
09/01/2020	<p>Template Update</p> <ul style="list-style-type: none"> ● Reformatted policy; transferred content to new template <p>Coverage Rationale</p> <ul style="list-style-type: none"> ● Revised list of conditions for which Functional Endoscopic Sinus Surgery (FESS) is proven and medically necessary: <ul style="list-style-type: none"> ○ Replaced “Chronic Rhinosinusitis” with “Chronic Rhinosinusitis <i>with or without polyps</i>” ○ Added: <ul style="list-style-type: none"> ▪ Polyposis with obstructive symptoms confirmed on computed tomography (CT) scan ▪ Sinonasal tumor confirmed on CT scan ○ Removed “tumor confirmed on CT scan (such as polyposis or malignancy)” ● Revised coverage criteria: <p><i>Chronic Rhinosinusitis</i></p> <ul style="list-style-type: none"> ○ Replaced criterion requiring: <ul style="list-style-type: none"> ▪ “Confirmation of Chronic Rhinosinusitis on a computed tomography (CT) scan meeting all of the [listed] criteria” with “confirmation of Chronic Rhinosinusitis on a computed tomography (CT) scan <i>for each sinus to be treated</i> meeting all of the [listed] criteria” ▪ “CT findings include mucosal thickening <i>or</i> obstruction <i>of the ostiomeatal complex</i>” with “CT findings include <i>ostial</i> obstruction (<i>outflow tract obstruction</i>) and mucosal thickening” ○ Added criterion requiring: <ul style="list-style-type: none"> ▪ CT images are obtained after completion of medical management ▪ Scoring of CT images is done by using the Modified Lund-Mackay Scoring System ▪ Sinonasal symptoms such as pain, pressure, or drainage are present on the same side as CT scan findings of rhinosinusitis <p><i>Recurrent Acute Rhinosinusitis</i></p> <ul style="list-style-type: none"> ○ Replaced criterion requiring:

Date	Summary of Changes
	<ul style="list-style-type: none"> ▪ “CT evidence of ostial and/or mucosal thickening in the sinus to be treated” with “CT <i>scan</i> evidence of ostial <i>obstruction (outflow tract obstruction)</i> and mucosal thickening in the sinus to be treated” ▪ “Sinonasal symptoms” with “sinonasal symptoms <i>such as pain, pressure, or drainage are present on the same side as CT scan findings of rhinosinusitis</i>” <p>Documentation Requirements</p> <ul style="list-style-type: none"> ● Updated required clinical information <p>Definitions</p> <ul style="list-style-type: none"> ● Added definition of “Modified Lund-Mackay Scoring System” <p>Supporting Information</p> <ul style="list-style-type: none"> ● Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information ● Archived previous policy version 2019T0578G

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.