

Balloon ostial dilation

We provide coverage for this procedure for adult and pediatric members who meet medical necessity criteria. Submit authorization requests through the e-referral system.

The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and we cannot authorize it, we will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. We may retrospectively monitor compliance with authorization requirements.

Applicable procedure codes: *31295, *31296, *31297, *31298

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See below for the questions you'll encounter in the e-referral system.

Q Has the patient had CHRONIC rhinosinusitis for at least 3 months with documented failure of medical therapy greater than 3 months demonstrated by persistent upper respiratory symptoms despite treatment consisting of ALL of the following (A-C)? A. Minimum of two different antibiotics. B. Trial of steroid nasal spray. C. Trial of antihistamine nasal spray and/or decongestant. Note: Must select N/A if patient has recurrent rhinosinusitis.

A

Possible answers: ☐ Yes ☐ No ☐ N/A

Q Has the patient had RECURRENT ACUTE rhinosinusitis (four or more episodes in 1 year) with documented failure of medical therapy for each episode consisting of ALL of the following (A-C)? A. Antibiotic therapy, if suspected bacterial infection. B. Saline nasal irrigation. C. Trial of steroid nasal spray. Note: Must select N/A if patient has chronic rhinosinusitis.

A

Possible answers: ☐ Yes ☐ No ☐ N/A

Preview questionnaire Balloon ostial dilation

For Medicare Plus BlueSM, Blue Care Network commercial and BCN AdvantageSM

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Q Does the patient have radiological evidence, in the sinus to be dilated, of at least one of the following (A-D)? A. Air fluid levels. B. Mucosal thickening. C. Opacification. D. Nasal polyposis.

A

Possible answers: ☐ Yes ☐ No ☐ N/A

Q Does the patient have at least ONE of the following conditions (A-E)? A. Ciliary dysfunction. B. Cystic Fibrosis. C. Sinonasal tumors or obstructive lesions. D. Severe/gross polypoid disease. E. Adolescent or child with incomplete bony development.

A

Possible answers: ☐ Yes ☐ No