Medical Coverage Policy

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Diagnostic Nasal/Sinus Endoscopy, Functional Endoscopic Sinus Surgery (FESS) and Turbinectomy

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not

covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses diagnostic nasal/sinus endoscopy, functional endoscopic sinus surgery (FESS), and turbinectomy procedures. For indications that are considered medically appropriate for diagnostic nasal/sinus endoscopy, FESS, and turbinectomy, please refer to the Coding Information section.

Coverage Policy

Diagnostic nasal/sinus endoscopy, functional endoscopic sinus surgery (FESS), and turbinectomy (see CPT® code lists below) are considered medically necessary when the associated signs and symptoms or diagnoses are listed in the Coding Information section for ANY of the following:

- **diagnostic nasal/sinus endoscopy:**

CPT® Code	Code Description
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
31235	Nasal/sinus endoscopy, diagnostic; with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)

- **functional endoscopic sinus surgery (FESS):**

CPT® Code	Code Description
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy
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

- **turbinectomy:**

CPT® Code	Code Description
30130	Excision inferior turbinate, partial or complete, any method
30140	Submucous resection inferior turbinate, partial or complete, any method
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)

Diagnostic nasal/sinus endoscopy, FESS, and turbinectomy procedures discussed within the scope of this Coverage Policy are not covered or reimbursable for any other indication.

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

ICD-10-CM Diagnosis Codes	Description
B49	Unspecified mycosis
C05.0	Malignant neoplasm of hard palate
C11.0-C11.9	Malignant neoplasm of nasopharynx
C30.0	Malignant neoplasm of nasal cavity

C31.0-C31.9	Malignant neoplasm of accessory sinuses
C41.0	Malignant neoplasm of bones of skull and face
C43.31	Malignant melanoma of nose
C4A.31	Merkel cell carcinoma of nose
C69.51-C69.52	Malignant neoplasm of lacrimal gland and duct
C69.61-C69.62	Malignant neoplasm of orbit
C78.39	Secondary malignant neoplasm of other respiratory organs
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C80.1	Malignant (primary) neoplasm, unspecified
D10.6	Benign neoplasm of nasopharynx
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D16.4	Benign neoplasm of bones of skull and face
D35.2	Benign neoplasm of pituitary gland
D38.5	Neoplasm of uncertain behavior of other respiratory organs
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
G47.33	Obstructive sleep apnea (adult) (pediatric)
G52.0	Disorders of olfactory nerve
G96.00	Cerebrospinal fluid leak, unspecified
G96.01	Cranial cerebrospinal fluid leak, spontaneous
G96.08	Other cranial cerebrospinal fluid leak
H04.011-H04.013	Acute dacryoadenitis
H04.111-H04.113	Dacryops
H04.201-H04.203	Unspecified epiphora
H04.211-H04.213	Epiphora due to excess lacrimation
H04.221-H04.223	Epiphora due to insufficient drainage
H04.301-H04.303	Unspecified dacryocystitis
H04.311-H04.313	Phlegmonous dacryocystitis
H04.321-H04.323	Acute dacryocystitis
H04.411-H04.413	Chronic dacryocystitis
H04.421-H04.423	Chronic lacrimal canaliculitis
H04.511-H04.513	Dacryolith
H04.521-H04.523	Eversion of lacrimal punctum
H04.531-H04.533	Neonatal obstruction of nasolacrimal duct
H04.541-H04.543	Stenosis of lacrimal canaliculi

H04.551-H04.553	Acquired stenosis of nasolacrimal duct
H04.561-H04.563	Stenosis of lacrimal punctum
H04.571-H04.573	Stenosis of lacrimal sac
H04.811-H04.813	Other disorders of lacrimal system
H04.9	Disorder of lacrimal system, unspecified
H05.011-H05.013	Cellulitis of orbit
H05.021-H05.023	Osteomyelitis of orbit
H05.331-H05.333	Deformity of orbit due to trauma or surgery
H68.021-H68.023	Chronic Eustachian salpingitis
H69.81-H69.83	Other specified disorders of Eustachian tube
H69.91-H69.93	Unspecified Eustachian tube disorder
J01.00-J01.91	Acute sinusitis
J30.0-J30.2	Vasomotor and allergic rhinitis
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J31.0	Chronic rhinitis
J32.0-J32.9	Chronic sinusitis
J33.0-J33.9	Nasal polyp
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	Cyst and mucocele of nose and nasal sinus
J34.2	Deviated nasal septum
J34.3	Hypertrophy of nasal turbinates
J34.81	Nasal mucositis (ulcerative)
J34.89	Other specified disorders of nose and nasal sinuses
J34.9	Unspecified disorder of nose and nasal sinuses
J35.2	Hypertrophy of adenoids
J39.8	Other specified diseases of upper respiratory tract
J39.9	Disease of upper respiratory tract, unspecified
J95.860	Postprocedural hematoma of a respiratory system organ or structure following a respiratory system procedure
J95.861	Postprocedural hematoma of a respiratory system organ or structure following other procedure
L03.211	Cellulitis of face
L03.213	Periorbital cellulitis
L98.0	Pyogenic granuloma
M31.2	Lethal midline granuloma
M95.0	Acquired deformity of nose

Q01.0	Frontal encephalocele
Q01.1	Nasofrontal encephalocele
Q01.8	Encephalocele of other sites
Q10.4-Q10.6	Congenital malformation of eyelid, lacrimal apparatus and orbit
Q30.0	Choanal atresia
Q30.3	Congenital perforated nasal septum
Q30.8	Other congenital malformations of nose
Q30.9	Congenital malformation of nose, unspecified
Q35.3	Cleft soft palate
Q35.9	Cleft palate, unspecified
Q37.5	Cleft hard and soft palate with unilateral cleft lip
Q37.9	Unspecified cleft palate with unilateral cleft lip
R04.0	Epistaxis
R06.83	Snoring
R06.89	Other abnormalities of breathing
R09.81	Nasal congestion
R09.82	Postnasal drip
R43.0	Anosmia
R43.1	Parosmia
R43.8	Other disturbances of smell and taste
R43.9	Unspecified disturbances of smell and taste
R48.1	Agnosia
R49.21	Hypernasality
R49.22	Hyponasality
S02.2XXA-S02.2XXS	Fracture of nasal bones
S02.80XD	Fracture of other specified skull and facial bones, unspecified side, subsequent encounter for fracture with routine healing
S02.80XG	Fracture of other specified skull and facial bones, unspecified side, subsequent encounter for fracture with delayed healing
S02.80XS	Fracture of other specified skull and facial bones, unspecified side, sequela
S02.81XA-S02.81XS	Fracture of other specified skull and facial bones, right side
S02.82XA-S02.82XS	Fracture of other specified skull and facial bones, left side
S02.92XA-S02.92XS	Unspecified fracture of facial bones
S09.92XA-S09.92XS	Unspecified injury of nose
T17.0XXA-T17.0XXS	Foreign body in nasal sinus
T17.1XXA-T17.1XXS	Foreign body in nostril
T70.1XXA-T70.1XXS	Sinus barotrauma
T78.40XA-T78.40XS	Allergy, unspecified
Z01.811	Encounter for preprocedural respiratory examination
Z48.810	Encounter for surgical aftercare following surgery on the sense organs
Z48.813	Encounter for surgical aftercare following surgery on the respiratory system

Z79.51	Long term (current) use of inhaled steroids
Z85.22	Personal history of malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
Z87.09	Personal history of other diseases of the respiratory system
Z87.730	Personal history of (corrected) cleft lip and palate

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	**Description**
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	**Description**
31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)

ICD-10-CM Diagnosis Codes	**Description**
C30.0	Malignant neoplasm of nasal cavity
C31.0	Malignant neoplasm of maxillary sinus
H04.551-H04.553	Acquired stenosis of nasolacrimal duct
J01.01	Acute recurrent maxillary sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.0-J30.2	Vasomotor and allergic rhinitis
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J32.0	Chronic maxillary sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J33.0-J33.9	Nasal polyp
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
L03.211	Cellulitis of face
R09.82	Postnasal drip
T17.0XXA-T17.0XXS	Foreign body in nasal sinus
T70.1XXA-T70.1XXS	Sinus barotrauma

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31235	Nasal/sinus endoscopy, diagnostic; with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)

ICD-10-CM Diagnosis Codes	Description
B49	Unspecified mycosis
C30.0	Malignant neoplasm of nasal cavity
C31.3	Malignant neoplasm of sphenoid sinus
D35.2	Benign neoplasm of pituitary gland
G96.00	Cerebrospinal fluid leak, unspecified
G96.01	Cranial cerebrospinal fluid leak, spontaneous
G96.08	Other cranial cerebrospinal fluid leak
J01.31	Acute recurrent sphenoidal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.1	Allergic rhinitis due to pollen
J30.2	Other seasonal allergic rhinitis
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J33.0-J33.9	Nasal polyp
J34.1	Cyst and mucocele of nose and nasal sinus
M31.2	Lethal midline granuloma
T70.1XXA-T70.1XXS	Sinus barotrauma

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)

ICD-10-CM Diagnosis Codes	Description
B49	Unspecified mycosis
C11.8	Malignant neoplasm of overlapping sites of nasopharynx
C11.9	Malignant neoplasm of nasopharynx, unspecified
C30.0	Malignant neoplasm of nasal cavity
C31.0	Malignant neoplasm of maxillary sinus
C31.9	Malignant neoplasm of accessory sinus, unspecified
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C80.1	Malignant (primary) neoplasm, unspecified
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
J01.00-J01.81	Acute sinusitis
J31.0	Chronic rhinitis
J32.0-J32.9	Chronic sinusitis
J33.0-J33.9	Nasal polyp
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	Cyst and mucocele of nose and nasal sinus
J34.3	Hypertrophy of nasal turbinates
J34.81	Nasal mucositis (ulcerative)
J34.89	Other specified disorders of nose and nasal sinuses
J95.860	Postprocedural hematoma of a respiratory system organ or structure following a respiratory system procedure
J95.861	Postprocedural hematoma of a respiratory system organ or structure following other procedure
L98.0	Pyogenic granuloma
R04.0	Epistaxis
R09.81	Nasal congestion
S02.2XXA-S02.2XXS	Fracture of nasal bones
T17.0XXA-T17.0XXS	Foreign body in nasal sinus

ICD-10-CM Diagnosis Codes	Description
T17.1XXA-T17.1XXS	Foreign body in nostril
Z48.810	Encounter for surgical aftercare following surgery on the sense organs
Z48.813	Encounter for surgical aftercare following surgery on the respiratory system
Z85.22	Personal history of malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
Z98.890	Other specified postprocedural states

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy

ICD-10-CM Diagnosis Codes	Description
C30.0	Malignant neoplasm of nasal cavity
H04.011-H04.013	Acute dacryoadenitis, right lacrimal gland
H04.111-H04.113	Dacryops
H04.201-H04.203	Unspecified epiphora
H04.211-H04.213	Epiphora due to excess lacrimation
H04.221-H04.223	Epiphora due to insufficient drainage
H04.301-H04.303	Unspecified dacryocystitis
H04.311-H04.313	Phlegmonous dacryocystitis
H04.321-H04.323	Acute dacryocystitis
H04.411-H04.413	Chronic dacryocystitis
H04.421-H04.423	Chronic lacrimal canaliculitis

H04.511-H04.513	Dacryolith
H04.521-H04.523	Eversion of lacrimal punctum
H04.531-H04.533	Neonatal obstruction of nasolacrimal duct
H04.541-H04.543	Stenosis of lacrimal canaliculi
H04.551-H04.553	Acquired stenosis of nasolacrimal duct
H04.561-H04.563	Stenosis of lacrimal punctum
H04.571-H04.573	Stenosis of lacrimal sac
H04.811-H04.813	Granuloma of lacrimal passage
J31.0	Chronic rhinitis
J32.2	Chronic ethmoidal sinusitis
Q10.4	Absence and agenesis of lacrimal apparatus
Q10.5	Congenital stenosis and stricture of lacrimal duct
Q10.6	Other congenital malformations of lacrimal apparatus

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	**Description**
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	**Description**
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection

ICD-10-CM Diagnosis Codes	**Description**
J01.21	Acute recurrent ethmoidal sinusitis
J30.0	Vasomotor rhinitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J31.0	Chronic rhinitis
J32.2	Chronic ethmoidal sinusitis
J32.4	Chronic pansinusitis
J33.0	Polyp of nasal cavity
J33.9	Nasal polyp, unspecified

ICD-10-CM Diagnosis Codes	Description
J34.3	Hypertrophy of nasal turbinates
J34.89	Other specified disorders of nose and nasal sinuses
Q30.8	Other congenital malformations of nose
Q30.9	Congenital malformation of nose, unspecified
R09.81	Nasal congestion

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed

ICD-10-CM Diagnosis Codes	Description
C30.0	Malignant neoplasm of nasal cavity
C31.1	Malignant neoplasm of ethmoidal sinus
C31.2	Malignant neoplasm of frontal sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
G96.00	Cerebrospinal fluid leak, unspecified
G96.01	Cranial cerebrospinal fluid leak, spontaneous
G96.08	Other cranial cerebrospinal fluid leak
H05.011-H05.013	Cellulitis of orbit
J01.10-J01.11	Acute frontal sinusitis
J01.20-J01.21	Acute ethmoidal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J32.1	Chronic frontal sinusitis

J32.2	Chronic ethmoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.0-J33.9	Nasal polyp
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
Q01.0	Frontal encephalocele
Q01.8	Encephalocele of other sites
R04.0	Epistaxis
R09.81	Nasal congestion
R43.0	Anosmia
R43.8	Other disturbances of smell and taste
T17.0XXA-T17.0XXS	Foreign body in nasal sinus

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	**Description**
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	**Description**
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)

ICD-10-CM Diagnosis Codes	**Description**
C30.0	Malignant neoplasm of nasal cavity
C31.1	Malignant neoplasm of ethmoidal sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
H04.201-H04.203	Unspecified epiphora
H04.221-H04.223	Epiphora due to insufficient drainage
H04.301-H04.303	Unspecified dacryocystitis of lacrimal passage
H04.321-H04.323	Acute dacryocystitis of lacrimal passage
H04.411-H04.413	Chronic dacryocystitis of lacrimal passage
H05.011-H05.013	Cellulitis of orbit

H05.021-H05.023	Osteomyelitis of orbit
J01.20-J01.21	Acute ethmoidal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J31.0	Chronic rhinitis
J32.2	Chronic ethmoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J33.0-J33.9	Nasal polyp
R04.0	Epistaxis
R09.81	Nasal congestion
R09.82	Postnasal drip
R43.0	Anosmia
R43.8	Other disturbances of smell and taste
T17.0XXA-T17.0XXS	Foreign body in nasal sinus
T70.1XXA-T70.1XXS	Sinus barotrauma

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	**Description**
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	**Description**
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)

ICD-10-CM Diagnosis Codes	**Description**
C30.0	Malignant neoplasm of nasal cavity
C31.1	Malignant neoplasm of ethmoidal sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
H04.221-H04.223	Epiphora due to insufficient drainage

H04.411-H04.413	Chronic dacryocystitis of right lacrimal passage
H05.011-H05.013	Cellulitis of orbit
J01.20-J01.21	Acute ethmoidal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J31.0	Chronic rhinitis
J32.2	Chronic ethmoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J33.0-J33.9	Nasal polyp
R04.0	Epistaxis
R09.81	Nasal congestion
R43.0	Anosmia
R43.8	Other disturbances of smell and taste
S02.2XXA-S02.2XXS	Fracture of nasal bones

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	**Description**
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	**Description**
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;

ICD-10-CM Diagnosis Codes	**Description**
C30.0	Malignant neoplasm of nasal cavity
C31.0	Malignant neoplasm of maxillary sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
H05.011-H05.013	Cellulitis of orbit
J01.00-J01.01	Acute maxillary sinusitis

J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J01.90-J01.91	Acute sinusitis, unspecified
J30.0-J30.2	Vasomotor and allergic rhinitis
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J31.0	Chronic rhinitis
J32.0	Chronic maxillary sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.1-J33.9	Nasal polyp
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
J34.9	Unspecified disorder of nose and nasal sinuses
L03.213	Periorbital cellulitis
R09.82	Postnasal drip
S02.81XA-S02.81XS	Fracture of other specified skull and facial bones, right side
S02.82XA-S02.82XS	Fracture of other specified skull and facial bones, left side
T17.0XXA-T17.0XXS	Foreign body in nasal sinus
T70.1XXA-T70-1XXS	Sinus barotrauma

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	**Description**
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	**Description**
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy

ICD-10-CM Diagnosis Codes	**Description**
C30.0	Malignant neoplasm of nasal cavity
C31.1	Malignant neoplasm of ethmoidal sinus

C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C31.9	Malignant neoplasm of accessory sinus, unspecified
D44.4	Neoplasm of uncertain behavior of craniopharyngeal duct
H04.201-H04.203	Unspecified epiphora
H04.221-H04.223	Epiphora due to insufficient drainage
H04.551-H04.553	Acquired stenosis of nasolacrimal duct
J01.20-J01.21	Acute ethmoidal sinusitis
J01.30-J01.31	Acute sphenoidal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.0	Vasomotor rhinitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J31.0	Chronic rhinitis
J32.2	Chronic ethmoidal sinusitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.0-J33.9	Nasal polyp
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
J34.9	Unspecified disorder of nose and nasal sinuses
L03.213	Periorbital cellulitis
R04.0	Epistaxis
R09.81	Nasal congestion
R43.0	Anosmia
R43.8	Other disturbances of smell and taste

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	**Description**
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus

ICD-10-CM Diagnosis Codes	Description
C30.0	Malignant neoplasm of nasal cavity
C31.1	Malignant neoplasm of ethmoidal sinus
C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C31.9	Malignant neoplasm of accessory sinus, unspecified
H05.011-H05.013	Cellulitis of orbit
H05.021-H05.023	Osteomyelitis of orbit
J01.21	Acute recurrent ethmoidal sinusitis
J01.31	Acute recurrent sphenoidal sinusitis
J01.41	Acute recurrent pansinusitis
J01.81	Other acute recurrent sinusitis
J30.2	Other seasonal allergic rhinitis
J30.89	Other allergic rhinitis
J30.9	Allergic rhinitis, unspecified
J31.0	Chronic rhinitis
J32.2	Chronic ethmoidal sinusitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J33.0	Polyp of nasal cavity
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
R09.81	Nasal congestion
R43.0	Anosmia
R43.8	Other disturbances of smell and taste

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus

ICD-10-CM Diagnosis Codes	Description
C30.0	Malignant neoplasm of nasal cavity
C31.0	Malignant neoplasm of maxillary sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C78.39	Secondary malignant neoplasm of other respiratory organs
H05.011-H05.013	Cellulitis of orbit
H05.021-H05.023	Osteomyelitis of orbit
J01.00	Acute maxillary sinusitis, unspecified
J01.01	Acute recurrent maxillary sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J32.0	Chronic maxillary sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.0-J33.9	Nasal polyp
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
R09.82	Postnasal drip

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed

ICD-10-CM Diagnosis Codes	Description
C30.0	Malignant neoplasm of nasal cavity
C31.2	Malignant neoplasm of frontal sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C31.9	Malignant neoplasm of accessory sinus, unspecified
G96.00	Cerebrospinal fluid leak, unspecified
G96.01	Cranial cerebrospinal fluid leak, spontaneous
G96.08	Other cranial cerebrospinal fluid leak
H05.011-H05.013	Cellulitis of orbit
H05.021-H05.023	Osteomyelitis of orbit
J01.10-J01.11	Acute frontal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.1	Allergic rhinitis due to pollen
J30.2	Other seasonal allergic rhinitis
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J32.1	Chronic frontal sinusitis
J32.4	Chronic pansinusitis
J32.8	Other chronic sinusitis
J32.9	Chronic sinusitis, unspecified
J33.0	Polyp of nasal cavity
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
R09.82	Postnasal drip
T70.1XXA-T70.1XXS	Sinus barotrauma

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;

ICD-10-CM Diagnosis Codes	Description
C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
G96.00	Cerebrospinal fluid leak, unspecified
G96.01	Cranial cerebrospinal fluid leak, spontaneous
G96.08	Other cranial cerebrospinal fluid leak
J01.30-J01.31	Acute sphenoidal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J34.1	Cyst and mucocele of nose and nasal sinus

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus

ICD-10-CM Diagnosis Codes	Description
C31.3	Malignant neoplasm of sphenoid sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
J01.30-J01.31	Acute sphenoidal sinusitis
J01.40-J01.41	Acute pansinusitis
J01.80-J01.81	Other acute sinusitis
J31.0	Chronic rhinitis
J32.3	Chronic sphenoidal sinusitis
J32.4	Chronic pansinusitis
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
J34.9	Unspecified disorder of nose and nasal sinuses

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
30130	Excision inferior turbinate, partial or complete, any method

ICD-10-CM Diagnosis Codes	Description
C30.0	Malignant neoplasm of nasal cavity
J30.0	Vasomotor rhinitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J33.0	Polyp of nasal cavity
J33.9	Nasal polyp, unspecified
J34.3	Hypertrophy of nasal turbinates
R09.81	Nasal congestion

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
30140	Submucous resection inferior turbinate, partial or complete, any method

ICD-10-CM Diagnosis Codes	Description
C30.0	Malignant neoplasm of nasal cavity
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
J31.0	Chronic rhinitis
J33.0	Polyp of nasal cavity
J33.9	Nasal polyp, unspecified
J34.0	Abscess, furuncle and carbuncle of nose
J34.3	Hypertrophy of nasal turbinates
R09.81	Nasal congestion
R09.82	Postnasal drip

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial

ICD-10-CM Diagnosis Codes	Description
J30.0	Vasomotor rhinitis
J30.1	Allergic rhinitis due to pollen

ICD-10-CM Diagnosis Codes	Description
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J33.0	Polyp of nasal cavity
J33.9	Nasal polyp, unspecified
J34.3	Hypertrophy of nasal turbinates
R09.81	Nasal congestion
R09.82	Postnasal drip

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)

ICD-10-CM Diagnosis Codes	Description
J30.0	Vasomotor rhinitis
J30.1	Allergic rhinitis due to pollen
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J33.8	Other polyp of sinus
J33.9	Nasal polyp, unspecified
J34.0	Abscess, furuncle and carbuncle of nose
J34.3	Hypertrophy of nasal turbinates
R09.81	Nasal congestion
R09.82	Postnasal drip

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
	All other diagnosis codes

General Background

Diagnostic nasal/sinus endoscopy is a minimally invasive procedure intended to directly visualize the anatomy of the nasal cavity and paranasal sinuses. The procedure is performed using an endoscope, typically in the office or outpatient setting. Diagnostic nasal/sinus endoscopy is indicated for a range of clinical scenarios, including evaluation of chronic sinonasal symptoms, post-treatment or postoperative assessment of sinusitis and/or nasal polyps, assessment and management of epistaxis, clear rhinorrhea suggestive of cerebrospinal fluid leak, and sinonasal neoplasms, and evaluation of smell disorders. Rhinoscopy, conventional radiography, and computed tomography (CT) may also be used to visualize the anatomy of the nasal cavity and paranasal sinuses. Rhinoscopy (anterior or posterior mirror-based examination) is inadequate for assessing deeper structures, as it only permits visualization of those directly in the line of sight. Conventional radiography has limited sensitivity, especially for detecting ethmoid disease, and is inadequate for evaluating chronic sinusitis or for determining specific areas requiring endoscopic surgical intervention. CT is widely regarded as the gold standard for preoperative planning, suspected complications of sinusitis, and for neoplasms of the nose and paranasal sinuses. Diagnostic nasal/sinus endoscopy offers the advantage of direct mucosal assessment and the ability to obtain cultures and/or biopsies (Payne, et al., 2025; Quan, et al., 2025; Shin, et al., 2025; Singh, et al., 2025; American Rhinologic Society, 2019; K Maru and Gupta, 2016; Slavin, et al., 2005).

Functional endoscopic sinus surgery (FESS), sometimes referred to as endoscopic sinus surgery (ESS), is a minimally invasive technique that utilizes a nasal endoscope and specialized instruments to access the paranasal sinuses, improve ventilation, and facilitate removal of disease. FESS is the primary surgical approach for chronic rhinosinusitis (CRS) refractory to medical therapy. The procedure is intended to widen the natural openings of the sinuses, reestablish proper airflow within the sinus cavities, enhance the movement of mucus, and facilitate improved delivery of topical medications. FESS is also used in the management of other sinonasal pathologies, including infectious complications of acute rhinosinusitis and benign or malignant tumors. CRS is often initially treated with antibiotics, topical or systemic corticosteroids, saline irrigation, antihistamines, mucolytics, expectorants, and decongestants. FESS may be considered for persistent symptoms of CRS, despite optimal medical therapy, or when medical therapy is not tolerated. Other approaches, such as open surgical techniques, are reserved for cases where endoscopic access is insufficient. Balloon sinus ostial dilation is another minimally invasive procedure that may be considered for select patients (Homsi and Gaffey, 2022; Shin, et al., 2025; Slavin, et al. 2005).

Turbinectomy encompasses a range of surgical interventions for inferior turbinate hypertrophy, including ablation, excision, and submucous resection. Inferior turbinate hypertrophy commonly occurs with chronic rhinitis, allergic rhinitis, and vasomotor rhinitis. Symptoms include nasal congestion, rhinorrhea, sneezing, and persistent nasal blockage. Turbinectomy is intended to relieve nasal obstruction by removing mucosa, soft erectile tissue, and/or bone, while optimally preserving turbinate function. Ablation involves destroying or reducing turbinate tissue using electrocautery, radiofrequency, or other methods. Excision may entail removing both the turbinate bone and mucosa together. Submucous resection (turbinoplasty) attempts to preserve the mucosal lining while removing the underlying bone and/or tissue. The initial management of inferior turbinate hypertrophy may include corticosteroids, saline irrigation, antihistamines, and decongestants. Turbinectomy may be considered for persistent symptoms despite optimal medical

therapy, or when medical therapy is not tolerated (Abdullah and Singh, 2021; Seidman, et al, 2015).

For indications that are considered medically appropriate for diagnostic nasal/sinus endoscopy, FESS, and turbinectomy, please refer to the Coding Information section.

U.S. Food and Drug Administration (FDA)

Nasal/sinus endoscopy, functional endoscopic sinus surgery (FESS), and turbinectomy are considered diagnostic or surgical procedures. These procedures do not require FDA review or approval.

Diagnostic Nasal/Sinus Endoscopy

Literature Review

According to high-quality evidence in the published, peer-reviewed scientific literature and evidence-based guidelines, diagnostic nasal/sinus endoscopy is indicated for a range of clinical scenarios, including evaluation of chronic sinonasal symptoms, monitoring for recurrence of sinusitis and/or nasal polyps, assessment and management of epistaxis, clear rhinorrhea suggestive of cerebrospinal fluid leak, and sinonasal neoplasms, and evaluation of smell disorders (Payne, et al., 2025; Quan, et al., 2025; Shin, et al., 2025; Singh, et al., 2025; American Rhinologic Society, 2019; K Maru and Gupta, 2016; Slavin, et al., 2005).

For indications that are considered medically appropriate for diagnostic nasal/sinus endoscopy, please refer to the Coding Information section.

Quan et al. (2025) conducted a prospective cross-sectional study to evaluate the correlation between diagnostic nasal endoscopy and computed tomography (CT) in diagnosing chronic rhinosinusitis (CRS). The study included 52 participants (average age: 51.57 ± 15.58 years) diagnosed with CRS. Participants underwent diagnostic nasal endoscopy followed by CT. Inclusion criteria included diagnosis of CRS based on European Position Paper on Rhinosinusitis and Nasal Polyps (2020) standards. Participants unable to complete all study required diagnostic procedures were excluded. Outcomes of interest included sensitivity, specificity, positive predictive value, negative predictive value, and mean endoscopic (Lund-Kennedy) and imaging (Lund-Mackay) scores. The study results revealed that the average Lund-Kennedy score was 3.83 ± 1.37 and the average Lund-Mackay score was 4.3 ± 2.4. Diagnostic nasal endoscopy demonstrated a high sensitivity (95.65%) and a high specificity (83.33%) when compared to CT. Positive predictive value was 97.78% and negative predictive value of 71.43%. The authors concluded that diagnostic nasal endoscopy was a valuable first-line tool for detecting CRS. Diagnostic nasal endoscopy may complement CT in achieving a more accurate diagnosis. It may also reduce the need for CT in appropriate cases. Further studies stratified by CRS phenotype were recommended to determine how diagnostic nasal endoscopy performs within subgroups. The authors noted several limitations including small sample size, limited number of visible polyps, inconsistent polyp visibility across modalities, and lack of detailed parameter-level comparisons. Additionally, adverse events were not reported and the study was a single-site design.

Singh et al. (2025) conducted a prospective observational study to evaluate the accuracy of diagnostic nasal endoscopy compared to CT in participants with CRS. The study included 109 participants aged 10 to 60 years presenting with CRS symptoms for more than 12 weeks. All participants underwent diagnostic nasal endoscopy and CT of the paranasal sinuses. The study excluded participants with acute rhinosinusitis and history of sinonasal trauma, sinonasal surgery, sinonasal tumor, or inverted papilloma. The primary outcomes measured were the correlation

between radiological and endoscopic findings, with the Lund-Mackay and Lund-Kennedy scoring systems used to assess sinus involvement and mucosal inflammation, respectively. The study results revealed a statistically significant correlation between endoscopic and radiological findings (χ^2=55.20, p<0.00000001), suggesting strong diagnostic concordance. Diagnostic nasal endoscopy demonstrated a sensitivity of 93.42%, specificity of 75.75%, positive predictive value of 89.33%, and negative predictive value of 83.33%. The authors concluded that diagnostic nasal endoscopy was a valuable, minimally invasive diagnostic tool for CRS, but CT remained essential for comprehensive anatomical assessment, especially in complex or refractory cases. A combined diagnostic approach was recommended. The authors noted several limitations, including the single-center design, limited sample size, absence of blinded comparison, lack of long-term follow-up, and no histopathological confirmation in ambiguous cases. Additionally, adverse events were not reported.

Functional Endoscopic Sinus Surgery (FESS)

According to high-quality evidence in the published, peer-reviewed scientific literature and evidence-based guidelines, functional endoscopic sinus surgery (FESS) is indicated for a range of clinical scenarios, including chronic rhinosinusitis, infectious complications of acute rhinosinusitis and benign or malignant tumors (Shin, et al., 2025; Fu, et al., 2023; Sujatha and Suja, 2019; Mandal and Sharma, 2019; Guttemberg, et al., 2019; Galluzzi, et al., 2018; Patel, et al., 2017; Zukin, et al., 2017; Jiang, et al., 2017; Smith, et al., 2013; Shen, et al., 2011; Soler, et al., 2010; Slavin, et al., 2005).

For indications that are considered medically appropriate for FESS, please refer to the Coding Information section.

Literature Review

Fu et al. (2023) conducted a systematic review and meta-analysis to determine the mean change in patients' scores on the 22-item Sino-Nasal Outcome Test (SNOT-22) before and after endoscopic sinus surgery (ESS) for CRS. Their objective was to evaluate whether ESS improved quality of life (QOL) in patients with CRS. The study included 15 multi-national, prospective cohort studies completed between 2009 and 2023. Included studies were either prospective or retrospective in nature; had to report the SNOT-22 score in patients with CRS, both before and after undergoing ESS; include patients with CRS who were 18 years of age or older; and had to provide data on the primary outcome (SNOT-22 scores). Excluded were studies with a follow-up duration of less than one month; healthy participants or individuals with disorders other than CRS who were not undergoing ESS. SNOT-22 results were the primary outcome and QOL outcomes were secondary. At an average follow-up of 25.5 months, all studies demonstrated a statistically significant difference in mean SNOT-22 scores between baseline and post-op time periods (p<0.05), ranging from 5.1 to 55.4. Across all studies, the mean SNOT-22 changed significantly by 26.02 (95% confidence interval [CI]: 12.83 to 38.60). The authors found that studies with higher mean age and pre-op SNOT-22 scores had greater changes in SNOT-22 scores following ESS, whereas trials with longer mean follow-up duration had smaller changes in SNOT-22 scores. Limitations of the study include the scarcity of studies available for inclusion, the heterogeneity of the study designs with varied inclusion criteria and duration of follow-up, the use of aggregated data rather than individual participant data, the variability of the delineation of primary outcomes, and the inclusion of studies only written in English. The authors concluded that ESS leads to enhanced QOL outcomes, and that improvement is influenced by the initial SNOT-22 score, the average age of the patients, and the duration of the follow-up period.

Sujatha and Suja (2019) published outcomes of a randomized controlled trial (RCT) involving 120 participants with CRS with bronchial asthma regarding the efficacy of FESS on QOL and pattern of improvement when performed as treatment for CRS. Study participants underwent FESS or drug therapy per standard protocol. Improvement after FESS was significant compared with control at 3, 6, 9, and 12 months, as measured by the Asthma Therapy Assessment Questionnaire, forced expiratory volume in 1 second, and QOL based on sinonasal outcome test. Data suggested an improvement with FESS in this study group.

Mandal and Sharma (2019) reported results of a study investigating the role of FESS in the enhancement of QOL in 30 patients with rhinosinusitis using the Glasgow Benefit Inventory questionnaire. Improvements were noted between results before and after surgery in mean total score, mean general Subscale Score, Mean Social Support Score and Mean Physical Health score. Data suggested a statistically significant improvement in all four scores before and after surgery.

Guttemberg et al. (2019) conducted a meta-analysis to estimate the sleep quality of patients with CRS after undergoing ESS. Four studies involving 509 participants were included in the systematic review. Improved sleep quality was observed in 90% of the patients. Improvement in each of the five symptoms related to sleep quality. Data suggested there are improved outcomes in sleep quality following ESS.

Galluzzi et al. (2018) performed a systematic review evaluating the recurrence rate of antrochoanal polyps (ACP) following surgery and the recurrence of ACP after different types of surgery. Thirteen studies involving children were included in the analysis (n=285). Studies were prospective and retrospective. The mean rate of recurrence after ACP surgery was 15.0%. FESS was the primary type of surgery (75%), followed by the combined approach (i.e., FESS with a trans-canine sinusoscopy or mini Caldwell-Luc) (14%), Caldwell-Luc (CWL) alone (8%), and simple polypectomy (SP) (2.8 %). A significant reduction of recurrences using the combined approach (0%) compared with FESS (17.7 %) or SP (50 %) ($p< 0.05$) was observed. No significant differences were noted with CWL (9.1%) and other surgical approaches ($p>0.05$). ESS was considered the first choice for primary treatment, while the external approach may be a valid option in case of recurrence.

Patel et al. (2017) reported results of a systematic review (six studies) with meta-analysis (five studies) regarding management of adult individuals with CRS refractory to appropriate medical therapy who progressed to medical or surgical therapy. Outcomes assessed were disease-specific QOL, nasal endoscopy, health-state utility, missed workdays, change in cardinal symptoms of CRS, economic impact, and adverse events. Compared to continued medical therapy, ESS significantly improved patient-based QOL scores ($p<0.00001$) and nasal endoscopy scores ($p<0.00001$). Difference in missed workdays depended heavily on patient choice of intervention. Unpooled analysis showed improvements in olfaction, health utility scores, and cost-effectiveness. Data suggested ESS significantly improved objective endoscopic scoring outcomes versus continued medical therapy alone. In patients with refractory CRS who had significant reductions in baseline QOL, surgery resulted in significant improvements. Continued medical therapy appeared to maintain outcomes in patients with less severe baseline QOL. Unpooled analysis demonstrated improvements in health utility, olfaction, and cost-effectiveness following ESS compared to continued medical therapy alone, in medically refractory CRS.

Zukin et al. (2017) published a systematic review of published studies describing outcomes after ESS for paranasal sinus mucoceles presenting with visual loss. Data from case reports and series were combined to analyze the associations among preoperative visual acuity, time to surgery and postoperative outcomes. Eighty-five studies were included that provided data on 207 patients. The average presenting visual acuity was 1.57 logMAR (logarithm of the minimum angle of resolution), and the average postoperative visual acuity was 0.21 logMAR, with visual improvement in 71.5%

of cases. Preoperative visual acuity ≥1.52 logMAR correlated with postoperative improvement >1 logMAR (p<.0001). A correlation was found between time to surgery less than 6 days and postoperative improvement (p<0.0001). Data suggested improved visual acuity outcomes following ESS for paranasal sinus mucoceles.

Jiang et al. (2017) performed a systematic review to evaluate the effectiveness of the endoscopic endonasal approach in sinonasal inverted papilloma in 125 patients. The overall recurrence rate was 8%. A common site of tumor origin was recorded to be from the maxillary sinus (40.2%). There was no significant difference in recurrence among stage of papilloma. Recurrence after endoscopic endonasal approach (8.4%) and a combined endoscopic and open exposure procedure (5.6%) were not significantly different (p>0.05). The recurrence rate was significantly (p<0.05) higher in patients with revision (15.6%) than in patients in the primary cases (3.8%). Twenty percent of recurrences were observed up to five years after surgery. Data suggested endoscopic surgery may be preferred for treating sinonasal inverted papilloma.

Smith et al. (2013) reported the results of a prospective study of 65 adult participants with CRS who failed initial medical therapy and who were considered surgical candidates by study criteria. Each participant was prospectively enrolled into a nonrandomized, multi-institutional cohort: medically managed (n=33), surgically managed with ESS (n=65), or crossover (from medical to surgical) (n=17). The primary outcome measure was disease-specific QOL. Bivariate and multivariate analyses compared QOL improvement between cohort groups. With one year follow up, surgical patients reported significantly more improvement than medically managed participants on the Rhinosinusitis Disability Index (RSDI) (p=0.039) or Chronic Sinusitis Survey (CSS) (p = 0.018). QOL in the crossover cohort was initially stagnant or worsening followed by improvement after ESS (RSDI, p=0.035; CSS, p=0.070). At one year follow-up, higher frequency of improvement was found in the surgical cohort versus medical cohort for several outcomes (total CSS: 70.8% versus 45.5%; p=0.014).

Shen et al. (2011) reported the outcomes of full-house (comprehensive) FESS (FHF) (complete sphenoethmoidectomy with Draf IIA frontal sinusotomy) in twenty-one patients with chronic sinusitis having had at least one previous sinus surgery. After a minimum six months of follow-up, patients were asked to complete a 5-item Patient Response Score (PRS). Objective measures collected included CT Lund MacKay score and endoscopic findings. Patients were divided into three subgroups based on months of follow up from surgery: 6 to 12, 12 to 18, and 18 to 24. No statistical difference in any outcome based on length of follow up was observed. Mean symptom outcome was reported as much improved. Both mucosal swelling and mucopus improved (p<0.001 and p<0.001, respectively). Lund MacKay score also improved (p<0.001). Presence of nasal polyps did not affect any subjective or objective outcome. Data suggested improvements in symptoms and mucosal findings with FHF between 6 and 24 months postoperatively.

Soler et al. (2010) conducted a prospective cohort trial to evaluate differences in endoscopy exam, olfactory function, and QOL status after ESS for participants with and without bilateral middle turbinate (BMT) resection. Study participants provided pre and postoperative responses to the Smell Identification Test (SIT), RSDI, CSS, and the Medical Outcomes Study Short Form-36 Health Survey (SF-36). Bivariate and multivariate analyses were performed. Forty-seven participants with BMT resection were compared to 195 participants without BMT resection with a mean follow-up of 17.4 months postoperatively. No significant differences in improvement were found in RSDI, CSS, or SF-36 scores between participants with BMT resection and those with BMT preservation (p>0.050). Participants undergoing BMT resection were more likely to show improvements in mean endoscopy (p=0.005) and olfaction (p=0.045) compared to those with BMT preservation. Data reflected no difference in QOL scores after baseline or after BMT resection, but greater improvements in SIT scores were found, which persisted after controlling for confounding factors.

Turbinectomy

According to high-quality evidence in the published, peer-reviewed scientific literature, turbinectomy is indicated for a range of clinical scenarios, including inferior turbinate hypertrophy that commonly occurs with chronic rhinitis, allergic rhinitis, and vasomotor rhinitis. (Mariano, et al., 2018; Seidman, et al., 2015; Leong, et al., 2010; Sapçi, et al., 2003; Passàli, et al., 2003; Powell, et al., 2001).

For indications that are considered medically appropriate for turbinectomy, please refer to the Coding Information section.

Literature Review

To evaluate if the middle turbinectomy has any repercussion on olfaction by using the University of Pennsylvania Smell Identification Test (UPSIT) as an assessment tool, Mariano et al. (2018) performed a prospective study of 27 participants who underwent middle turbinectomy. Participants were tested with the UPSIT pre- and post-surgery, with a minimum interval of 3 months. Twenty-five Participants completed the study. There was no statistical correlation between middle turbinectomy and the UPSIT score, suggesting no clinical effect on olfaction from partial middle turbinectomy.

Leong et al. (2010) evaluated the evidence in 11 studies for inferior turbinate surgery in children suffering with chronic nasal congestion. The ages of the study participants were from 1 to 17 years at the time of surgery and were followed-up for a period of 3 months to 14 years. Surgical indication for all studies was chronic nasal congestion, resistant to a trial of medical treatment for 2 to 3 months preceding surgery. Of the 730 cases reviewed, 79.1 % had turbinate surgery as a standalone procedure. Although all studies generally supported the effectiveness of turbinate reduction surgery for inferior turbinate hypertrophy, the outcome measures used were varied and did not allow comparison across studies. The authors noted there is currently little evidence to support turbinate reduction surgery in children. The role of surgery, if any, has not been properly examined. Furthermore, the long-term effects on nasal airflow dynamics, nasal physiology and long-term complications remain to be studied.

Sapçi et al. (2003) reported results of a prospective randomized clinical trial. The study involved three groups of 45 adult participants with symptoms and signs of nasal obstruction and stuffiness related to enlarged turbinates. In group A, laser ablation was applied to the inferior turbinate on one side and partial turbinectomy to the inferior turbinate on the other side. In group B, radiofrequency tissue ablation was applied to the inferior turbinate on one side and partial turbinectomy to the inferior turbinate on the other side. In group C, participants who were not treated by any surgical techniques were the control subjects. Clinical examinations, visual analogue scales, rhinomanometry, and isotopic study of nasal mucociliary transport time were used to assess treatment outcomes. Data suggested that radiofrequency tissue ablation to the turbinate is effective in improving nasal obstruction objectively and in preserving nasal mucociliary function. With the partial turbinectomy technique, results obtained were similar to the results with the radiofrequency tissue ablation technique.

Passàli et al. (2003) published results of a prospective study of 457 patients with symptoms of nasal obstruction. Three hundred eighty two underwent inferior turbinectomy. Inclusion criteria for surgical intervention were the presence of chronic allergic or vasomotor rhinitis leading to chronic nasal obstruction and a lack of efficacy of medical treatment. The patients were randomly assigned to one of six therapeutic groups; the groups did not differ in regard to the severity of disease before surgery. Of the 382 patients initially enrolled in the trial, 348 were followed up for

a maximum of six years. The authors reported that inferior turbinectomy conferred significant relief of nasal obstruction, but was associated with more complications, notably, intense pain, crusting, and bleeding. Atrophic rhinitis and empty nose syndrome were recognized as late sequelae of this procedure, especially following total turbinectomy.

Powell et al. (2001) published results of a prospective, randomized, double-blind, placebo-controlled clinical pilot study estimating the treatment effect of temperature-controlled radiofrequency (TCRF) reduction of turbinate hypertrophy in 22 participants with sleep-disordered breathing (SDB) treated with nasal continuous positive airway pressure (CPAP). Participants were randomly assigned to either TCRF turbinate treatment (n=17) or placebo control (n=5). Changes in nasal obstruction were assessed between pre-treatment and four weeks post-treatment. Data suggested that TCRF turbinate treatment appears to benefit nasal obstruction and CPAP treatment for SDB. A future definitive trial is feasible to establish the statistical significance of these findings.

Professional Societies/Organizations

American Academy of Allergy, Asthma and Immunology (AAAAI)/American College of Allergy, Asthma and Immunology (ACAAI): The Joint Task Force on Practice Parameters, representing AAAAI, ACAAI, and the Joint Council of Allergy, Asthma and Immunology (Slavin, et al. 2005) published a practice parameter update regarding the diagnosis and management of sinusitis that states:

- "Summary Statement 22: Clinical signs of acute sinusitis include sinus tenderness on palpation, mucosal erythema, purulent nasal secretions, increased pharyngeal secretions, and periorbital edema." Strength of recommendation: C "Directly based on category III evidence or extrapolated recommendation from category I or II evidence"
- "In selected patients with chronic or recurrent sinusitis, nasal endoscopy should be considered. This procedure provides ideal direct visualization of abnormalities of the septum, turbinates, mucosa, nasopharynx, adenoids, eustachian tube orifice, tonsils, posterior tongue, epiglottis, glottis, and vocal cords. The origin and extent of nasal polyps can be identified, as well as the presence of purulent ostial secretions."
- "Summary Statement 82: Functional endoscopic sinus surgery, in combination with appropriate medical therapy, has been shown in uncontrolled studies to have long-term efficacy in reducing disease-specific symptoms and in improving overall quality of life." Strength of recommendation: C
- "The surgical treatment of sinusitis has been significantly enhanced by the routine use of nasal endoscopy and by the use of CT imaging. The nasal telescope has significantly improved our ability to visualize the ostiomeatal complex, a critical region in the pathogenesis of chronic sinusitis and a region that is very poorly visualized on both anterior rhinoscopy and on standard radiographic films. Although chronic sinusitis is typically a multifactorial disease with environmental and general host factors, localized persistent disease within the ostiomeatal complex plays a significant part in continuation of the disease process. Functional endoscopic sinus surgery results in significant improvement in the majority of patients. However, significant improvement often requires a combination of appropriate surgical intervention with intensive postoperative local management to the region and appropriate medical therapy."
- "Indications for surgical intervention:
  - When nasal polyps obstruct sinus drainage and persist despite appropriate medical treatment.
  - When there is recurrent or persistent infectious sinusitis despite adequate trials of medical management: adequate medical management minimally involves multiple courses of antibiotics chosen to cover the spectrum of pathogens anticipated to be causing the disease.

- For biopsy of the nasal mucosa to rule out granulomatous disease, neoplasms, ciliary dyskinesia, or fungal infections.
- When maxillary antral puncture is required.
- When anatomic defects exist that obstruct the sinus outflow tract, particularly including the ostiomeatal complex (and adenoidal tissues in children) and are thought to be contributing to recurrent or chronic infectious sinusitis.
- For sinusitis with threatened complications (eg, threat of brain abscess, meningitis, cavernous sinus thrombosis, or Pott's tumor)."

American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS): AAO-HNS (Payne, et al., 2025) clinical practice guidelines (CPGs) for adult sinusitis include:

- "Statement 7a: Diagnosis of Chronic Rhinosinusitis (CRS) or Recurrent Acute Rhinosinusitis (RARS)" "Clinicians should distinguish CRS and RARS from isolated episodes of acute bacterial rhinosinusitis and other causes of sinonasal symptoms." "Recommendation based on cohort and observational studies with a preponderance of benefit over harm." "Aggregate evidence quality: Grade C, cohort and observational studies." "Level of Confidence in Evidence: High." "In a meta-analysis evaluating the accuracy of diagnosing CRS by nasal endoscopy compared with paranasal sinus CT, 16 observational and retrospective studies were reviewed concluding that there was a high correlation ($P < .0001$, 95% CI 0.7685–0.9401) between the 2 exams in diagnosing CRS." "Risk of nasal endoscopy is minimal but can include bleeding and patient discomfort." "Nasal endoscopy does have limitations in diagnosing CRS without polyposis because of the difficulty visualizing inside the sinus cavities, whereas CT can distinguish obstruction of ostiomeatal complex and opacification/mucosal thickening of sinus cavities."
- "Statement 7b: Objective Confirmation of a Diagnosis of Chronic Rhinosinusitis (CRS)" "The clinician should confirm a clinical diagnosis of CRS with objective documentation of sinonasal inflammation, which may be accomplished using anterior rhinoscopy, nasal endoscopy, or computed tomography." "Strong recommendation based on cross-sectional studies with a preponderance of benefit over harm." "Aggregate evidence quality: Grade B, cross-sectional studies. "Level of Confidence in Evidence: High." "Direct visualization is best accomplished with nasal endoscopy, but in some patients anterior rhinoscopy using an otoscope or nasal speculum may suffice." "A systematic review assessed the diagnostic value of nasal endoscopy for adults with suspected CRS, using CT imaging as the gold-standard for diagnostic certainty. Compared with baseline risk for CRS, a positive nasal endoscopy (pus or polyps) had an added value for confirming CRS of 25% to 28% and a negative nasal endoscopy had an added value of ruling out CRS of 5% to 30%. The authors concluded that nasal endoscopy should be a first-line confirmatory test for CRS, reserving CT scanning for patients with a prolonged or complicated clinical course." "In cases of large polyps or gross purulence, anterior rhinoscopy may be sufficient; however, nasal endoscopy is superior in that it also allows visualization of the posterior nasal cavity, nasopharynx, and the sinus drainage pathways in the middle meatus and superior meatus. Advantages of nasal endoscopy over anterior rhinoscopy include identification of posterior septal deviations, polyps or secretions in the posterior nasal cavity, and polyps or secretions within the middle meatus or in the sphenoethmoidal recess. Further, nasal endoscopy allows directed aspiration of abnormal secretions for analysis and culture."
- "Statement 10: Chronic Rhinosinusitis (CRS) With Polyps" "The clinician should confirm the presence or absence of nasal polyps in a patient with CRS." "Recommendation based on observational studies with preponderance of benefit over harm." "Aggregate evidence quality: Grade A, systematic review of multiple RCT." "Level of Confidence in Evidence: Medium." "Identifying nasal polyps requires careful examination of the nasal airway. Large polyps, which obstruct the nasal cavity, may be easily visualized with a nasal speculum or hand-held otoscope (ie, anterior rhinoscopy); doing so after nasal decongestion with

vasoconstrictive agents such as oxymetazoline may improve visualization. Smaller nasal polyps in the middle meatus or in the posterior nasal cavity, however, may only be detected by nasal endoscopy. A clinician who suspects nasal polyps in a patient with CRS, either from suspicious anterior rhinoscopy or in the setting of a constellation of comorbid conditions/symptoms such as atopy, asthma and/or waxing and waning sense of smell, and is unable to perform nasal endoscopy should refer the patient to a clinician who can thoroughly examine the entire nasal cavity."

AAO-HNS (Shin, et al., 2025) CPGs for the surgical management of CRS include:

- "Statement 1: Verification of Diagnosis and Assessment of Candidacy for Surgery" "1A: The surgeon should verify an existing diagnosis of CRS to ensure established diagnostic criteria (signs and symptoms) from CPGs are met. AND 1B: The surgeon should assess candidacy for sinus surgery based on symptoms, disease characteristics, QOL, and prior medical or surgical therapy." "Evidence strength: Strong recommendation based on multiple CPGs and SRs." "Aggregate evidence quality. B, cross-sectional studies with consistent reference standards, prior definitions from CPGs." (Action 1A) "Aggregate evidence quality. B, cross-sectional studies with consistent reference standards." (Action 1B) "It is helpful to identify objective findings of inflammation, for example, by anterior rhinoscopy, endoscopy, and/or CT scan."
- "Statement 2: No One-Size-Fits-All Regimen" "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." "Evidence strength: Recommendation based on RCTs and meta-analyses that show variable quality in the types of medical therapeutics for the treatment of CRS." "Aggregate evidence quality. B, RCT, meta-analyses; data for topical steroids and rinses is strong; evidence for antibiotics is more limited." "Level of confidence in the evidence. High."
- "Statement 4: Relative Benefits of Surgery or Medical Therapy Alone" "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." "Evidence strength. Recommendation based on a limited number of RCTs and multiple observational studies that demonstrate consistent benefit over harm through avoidance of delays in care and disease progression when timely surgery is provided as part of an overall care plan; insufficient equipoise to pursue trials comparing medical therapy alone and surgery in cases of CRS with skull base erosion, eosinophilic mucin rhinosinusitis, allergic fungal rhinosinusitis (AFRS), or fungal ball due to concerns about disease progression and harm to surrounding anatomic structures." "Aggregate evidence quality. B, based on RCTs and large observational studies for CRSwNP [CRS with nasal polyposis]; C, nonrandomized cohort studies with consistent benefits for AFS; C, prior guideline recommendations with limited data for fungal ball; X, lack of equipoise regarding trials for erosive disease." "Level of confidence in the evidence. High for CRS with polyps; moderate for AFS and fungal ball as controlled studies are inherently limited for erosive disease processes."
- "Statement 5: Patient Education About Surgery and Long-Term Management" "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." "Evidence strength: Recommendation based on moderate quality evidence (levels B and C)." "Aggregate evidence quality. B and C, observational studies regarding chronic disease states, using applications and videos for patient education; observational and case-control studies regarding sinonasal rinses." "Level of confidence in the evidence. Moderate based on the

evidence that is available showing that educated patients can be better involved in decisions about their care."

- "Statement 6: When to Offer Sinus Surgery" "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." "Evidence strength: Recommendation based on cohort studies and one RCT that support a preponderance of benefit over harm." "Aggregate evidence quality. B and C, primarily C with some B; cohort studies support surgery over continued medical therapy alone; one RCT of CRS with polyps treated with medical therapy alone compared to medical therapy with ESS showed improvement in the surgical arm." "Level of confidence in the evidence. Moderate to high confidence in existing data, higher for CRS with polyps than CRS without polyps."

AAO-HNS (Seidman, et al., 2015) CPGs for allergic rhinitis include "Statement 12. Inferior Turbinate Reduction: Clinicians may offer, or refer to a surgeon who can offer, inferior turbinate reduction in patients with AR with nasal airway obstruction and enlarged inferior turbinates who have failed medical management. Option based on observational studies, with a preponderance of benefit over harm." "Aggregate evidence quality: Grade C, based on observational studies" "Level of confidence in the evidence: Moderate"

American Rhinologic Society (ARS): An ARS (2019) position statement for diagnostic nasal endoscopy (CPT code: 31231) states: "Diagnostic nasal endoscopy is a procedure performed to better characterize the anatomy of the nasal cavity and/or paranasal sinuses and to identify sinonasal pathology not afforded by anterior rhinoscopy. It is typically performed in the office setting, although it can be performed in the hospital outpatient setting. Common indications for diagnostic nasal endoscopy include but are not limited to:

- Evaluation of chronic sinonasal symptoms;
- Assessment of interval response to medical or surgical therapy;
- Monitoring for recurrence of sinusitis and/or nasal polyps;
- Evaluation and management of epistaxis;
- Performance of endoscopically guided cultures;
- Assessment of facial pain suggestive of nasal origin;
- Evaluation of clear rhinorrhea suggestive of cerebrospinal fluid leak;
- Performance of initial diagnosis and interval surveillance for sinonasal neoplasms; or
- Evaluation of smell disorders.

Endoscopic evaluation and endoscopic surgery have both been recognized as accepted modalities of diagnosis and treatment of sinonasal disorders.

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Data on health care disparities for chronic rhinosinusitis (CRS) are lacking. A retrospective study from 2019 reported that patients of lower socioeconomic status had a longer duration of disease prior to surgery; more often had nasal polyposis; and had decreased access to care, as indicated by increased surgical wait times and being lost to follow-up (Duerson, et al., 2019).

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Revision Details

Type of Revision	Summary of Changes	Date
Annual Review	• No clinical policy statement changes.	3/15/2026
Annual Review	• No policy statement changes.	3/15/2025
Annual Review	• No policy statement changes.	3/17/2024