



Stereotactic navigation in sinus surgery

Clinical Policy ID: CCP.1455

Recent review date: 4/2026

Next review date: 8/2027

Policy contains: Computer-assisted sinus surgery; endoscopic sinus surgery; image-guided sinus surgery; surgical navigation.

First Choice Next has developed clinical policies to assist with making coverage determinations. First Choice Next's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered, on a case by case basis, by First Choice Next when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. First Choice Next's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. First Choice Next's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, First Choice Next will update its clinical policies as necessary. First Choice Next's clinical policies are not guarantees of payment.

Coverage policy

Stereotactic navigation (also known as three-dimensional image guidance or computer-aided surgery) is considered standard of care when added to general endoscopic sinus surgery; therefore, it is not separately reimbursable as an add-on to the general procedure.

Limitations

No limitations were identified during the writing of this policy.

Alternative covered services

- Clinical examination.
- Diagnostic rhinoscopy.
- Endoscopic or open sinus surgery.
- Preoperative and postoperative radiography, computed tomography, or magnetic resonance imaging.
- Professional consultation.

Background

Sinus surgery is one of the most frequently performed surgical operations in the United States, and the most common indication is chronic refractory rhinosinusitis. Since the late 1990s, there has been a shift from open procedures to endoscopic procedures and a decrease in the incidence of major complications associated with endoscopic approaches in adults. For example, in England from 2010 to 2019, the number of endoscopic sinus procedures increased by 21.1%, and the number of open procedures declined by 35.3% (Gupta, 2020).

Rhinosinusitis is a clinical diagnosis, dependent on clinical and rhinoscopic findings. Some diseases involving the sinonasal region and skull base are inaccessible to sinonasal endoscopy or are not directly visible on clinical examination. In such cases, imaging can determine the extent and possible nature of the disease and provide guidance for surgical planning.

Multidetector or cone-beam computed tomography is the preferred imaging modality for surgical planning in most circumstances for its clear delineation of the complex ethmoidal anatomy, ostiomeatal unit, and anatomic variations, including the presence of sphenoethmoidal (Onodi) air cells (American College of Radiology, 2021). Magnetic resonance imaging of the face and sinuses with inclusion of adjacent brain and orbits is preferred for soft-tissue masses, delineation of orbital, skull base, or intracranial involvement, and for suspected invasive fungal sinusitis.

Endoscopic sinus surgery is a set of minimally invasive techniques that apply endoscopic instrumentation to directly examine the sinuses, remove sinus blockages, and restore sinus ventilation and normal function. It is a treatment of choice for chronic rhinosinusitis refractory to medical treatment, and its role is expanding in the management of other sinus, orbit, and skull base diseases (Homsí, 2022).

Endoscopic sinus surgery is a technically demanding procedure due to anatomical complexity, variation in normal anatomy, and proximity to critical structures such as the olfactory fossa, skull base, vascular structures, and orbit. Anatomic distortion from chronically inflamed mucosa and absent anatomic landmarks from prior surgery further increase both potential risk of major and minor complications and operating time.

In a systematic review/meta-analysis of 13 studies (n = 1,274) of complications from endoscopic sinus surgery for chronic rhinosinusitis, the complication rate was 5.3% with enhanced recovery after surgery – a multimodal multi-disciplinary planning program – compared to the 19.1% rate using standard care (Wu, 2023). To optimize the visual surgical field and mitigate the risk of complications, stereotactic navigation has been proposed as an adjunct in endoscopic and external-approach sinus surgery.

The image guidance systems consist of a computer workstation, tracking system, and specially designed navigation instruments (Oakley, 2016). They require a compatible preoperative computed tomography scan of the sinuses using a special image guidance protocol, for example, a non-contrast axial image with 1 millimeter or thinner cuts. Image guidance systems digitally link the images and display them in axial, coronal, and sagittal planes. The image is coupled to the surgical instruments by an electromagnetic or optical tracking system. This gives the surgeon the ability to navigate the surgical instruments in real time within the diseased sinuses and improve the spatial orientation with vital structures while watching the monitor.

Findings

Guidelines

The American Academy of Otolaryngology — Head and Neck Surgery (2023) recommends stereotactic navigation based on consensus and current evidence, acknowledging that corroboration with Level 1 evidence would be impossible. They recommend the technology be used at the surgeon's discretion to clarify complex anatomy during sinus and skull base surgery. Specific indications include revision sinus surgery, distorted sinus

anatomy of development, postoperative, or traumatic origin, and extensive sino-nasal polyposis. Additional indications encompass pathology involving the frontal, posterior ethmoid, or sphenoid sinuses; disease abutting the skull base, orbit, optic nerve, or carotid artery; cerebrospinal fluid rhinorrhea or conditions where there is a skull base defect; and benign and malignant sino-nasal neoplasms.

A guideline from the International Stereotactic Radiosurgery Society recommends stereotactic radiosurgery as a treatment for grade 1 meningioma (Marchetti, 2020).

A clinical practice guideline from the American Academy of Otolaryngology on the surgical management of chronic rhinosinusitis in adults includes a recommendation (KAS 7) that surgeons obtain a computed tomography scan with a fine-cut protocol for surgical planning (Shin, 2025). The guideline's value judgments state that image guidance is not mandatory but acknowledge that fine-cut protocols form a reliable basis for image guidance when it is utilized. The guideline also notes increasing use of image guidance during revision surgery. These positions are consistent with the Academy's existing position statement recommending stereotactic navigation at the surgeon's discretion.

Systematic Reviews

Two qualitative systematic reviews (Ramakrishnan, 2013; von Hofsten, 2013) failed to demonstrate a definitive reduction in complications or improvement in outcomes with stereotactic navigation. These conclusions may reflect the inability to conduct more definitive studies rather than a lack of efficacy. Individual primary studies lacked statistical power to identify a meaningful effect of stereotactic navigation in endoscopic sinus surgery.

A systematic review/meta-analysis of 27 studies found that stereotactic radiosurgery for benign intracranial meningiomas had a local control rate from 71% to 100% and progression-free-survival rate from 55% to 97% after 10 years, with a low toxicity rate (Marchetti, 2020).

A systematic review of 47 studies on endoscopic sinus surgery found the most commonly identified significant landmarks were maxillary sinus ostium; orbital wall; frontal recess; skull base; ground lamella; fovea posterior; and sphenoid sinus ostium. These landmarks may lead to systematic practice guidelines in navigated endoscopic sinus surgery (Baudoin, 2021).

A systematic review/meta-analysis of twenty-one studies ($n = 705$) of patients treated with stereotactic radiosurgery for dural arteriovenous fistulas found that non-cavernous sinus fistulas were associated with lower rates of complete obliteration ($P = .03$) and symptom cure rate ($P = .001$) (Singh, 2022).

A systematic review/meta-analysis of five studies ($n = 208$) of patients with pituitary adenomas who underwent endoscopic resection of the medial wall of the cavernous sinus showed the prevalence of medial wall invasion varied from 10.4% to 36.7% (de Macedo Filho, 2022).

Meta-Analyses

A meta-analysis (Dalgorf, 2013) of 14 comparative cohorts found both major complications ($P = .007$) and total complications ($P = .02$) were more common in the non-image guided group. However, there were no significant between-group differences in risk of orbital complications, intracranial complications, major hemorrhage, completion of operation, revision surgery, or patient-reported outcome measures.

Another meta-analysis (Vreugdenburg, 2016) of nine studies demonstrated a statistically significant decrease in the likelihood of total, major, and orbital complications in participants who had stereotactic navigation. However, a statistical benefit in reducing surgical revisions, major hemorrhage, or minor complications was not observed.

A systematic review and meta-analysis of 16 studies ($n = 3,014$) of patients with chronic rhinosinusitis undergoing endoscopic sinus surgery with versus without image-guided systems found that image guidance was associated with lower total complications ($OR = 0.52$, $P < .01$), lower recurrence ($OR = 0.31$, $P < .001$), and lower revision

surgery rates (OR = 0.59, P = .04) (Lyu, 2025). Image guidance was also associated with reduced intraoperative blood loss (weighted mean difference = -10.74 mL, P = .04) and reduced surgical time (weighted mean difference = -6.25 minutes, P < .001). The authors noted limitations including reliance on observational studies, potential selection bias toward more complex cases in the image-guided group, and heterogeneity in disease severity reporting across studies.

A meta-analysis of 21 studies (n = 199) of participants undergoing surgery for cavernous sinus hemangiomas found that 149 of the participants received standalone stereotactic radiosurgery, of whom 72.4% had greater than a 50% decrease in tumor volume, after being followed for an average of three years (Mishra, 2023).

Clinical Studies and Surveys

The perceived potential of increased safety and improved surgical outcomes with stereotactic navigation in endoscopic sinus surgery led to the introduction and diffusion of the technology in the early 2000s, despite the absence of clear benefit demonstrated in clinical research. A survey of American Rhinologic Society members showed growth in both the availability of stereotactic navigation to most practitioners and its use from 2005 to 2010 (P < .0001) (Justice, 2012).

American Rhinologic Society survey respondents identified primary anterior ethmoidectomy, revision anterior ethmoidectomy, primary total ethmoidectomy, Lothrop procedure, cerebrospinal fluid leak repair, tumor surgery, orbital decompression, and optic nerve decompression (all P < .05) as major indications for stereotactic navigation (Justice, 2012). These indications suggest stereotactic navigation is best reserved for situations with highest risk of major surgical complications or where suboptimal surgery may lead to poorer outcomes or revision procedures.

A cost-effectiveness study of pediatric patients who underwent sinus surgery with intraoperative navigation (n = 60) and without intraoperative navigation (n = 59) between 2003 and 2016 found that intraoperative navigation was associated with more complex surgeries with more sinuses opened (P = .008), increased presence of the attending surgeon and a trainee (P < .001 for both), and longer surgical time (P < .001). The study concluded that intraoperative navigation did not decrease complication rates or revision rates and was not cost-effective, being used primarily as an educational tool or to increase confidence in intraoperative landmark identification.

A randomized study (n = 200) of participants undergoing endoscopic sinus surgery with versus without an image-guided system in China found four re-hospitalizations and re-operations due to bleeding in the group without image guidance, compared with none for the image guidance group. Total costs were slightly greater for the group without image guidance due to re-hospitalizations (Wang, 2023).

In 2026, we added a new clinical practice guideline on the surgical management of chronic rhinosinusitis (Shin, 2025) and a new systematic review and meta-analysis on clinical outcomes of image-guided endoscopic sinus surgery (Lyu, 2025). No policy changes were warranted.

References

On March 16, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “otorhinolaryngologic surgical procedures (MeSH),” “paranasal sinus diseases/surgery (MeSH),” and “Surgery, Computer-Assisted (MeSH),” and “endoscopic sinus surgery.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

4/2020: initial review date and clinical policy effective date: 5/2020

4/2021: Policy references updated.

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4/2024: Policy references updated.

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Related codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1455 This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code description
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including frontal sinus exploration; with or without removal of tissue from frontal sinus
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 sphenoid sinus
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus

Code	Code description
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine fossa
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g., balloon dilation)
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g., balloon dilation)
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (e.g., balloon dilation)
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural (add-on code)
70486	Computed tomography, maxillofacial area, without contrast material