Steroid-Eluting Sinus Stents

Policy Number: 7.01.134  Last Review: 12/2019
Origination: 12/2015  Next Review: 12/2020

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will not provide coverage for Implantable Sinus Stents for Postoperative Use Following Endoscopic Sinus Surgery. This is considered investigational.

When Policy Topic is covered
n/a

When Policy Topic is not covered
The use of steroid-eluting sinus stents for postoperative treatment following endoscopic sinus surgery and for treatment of recurrent sinonasal polyposis is considered investigational.

The use of drug-eluting sinus stents is considered investigational in all other conditions.

Considerations
Sinus stents are defined as implantable devices that are specifically designed to improve patency and/or deliver local medication. These devices are inserted under endoscopic guidance and are distinguished from sinus packing and variations on packing devices routinely employed after sinus surgery.

Foam dressings, such as SinuFoam™, are used as nasal packs for a variety of conditions, including nosebleeds, and have also been used post-ESS. These are considered different types of nasal packing.

Middle meatal spacers are related but separate devices that are intended to maintain sinus patency post-ESS. They are splint-like devices that are inserted directly rather than under endoscopic guidance, and they do not have the capability of delivering local medication.

Category III codes 0406T and 0407T were deleted effective 12/31/18. Per coding guidelines, effective 1/1/2019, to report endoscopic placement of a drug-eluting implant in the ethmoid sinus without any other nasal/sinus endoscopic surgical services, use CPT 31299. To report endoscopic placement of a drug-eluting
implant in the ethmoid sinus in conjunction with biopsy, polypectomy, or debridement, use CPT 31237.

There is a HCPCS code for the Propel device:

S1090: Mometasone furoate sinus implant, 370 micrograms.

Drug eluting stents might also be billed with J3490: Unclassified drug

Facility billing for drug eluting stents might use:

C2625 – Stent, non-coronary, temporary, with delivery system may be used by facilities for these stents.

C1874 Stent, coated/covered, with delivery system.

**Description of Procedure or Service**

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: • With chronic rhinosinusitis who have undergone endoscopic sinus surgery</td>
<td>Interventions of interest are: • Implantable steroid-eluting sinus stents</td>
<td>Comparators of interest are: • Standard management (including topical steroid, packing, and irrigation)</td>
<td>Relevant outcomes include: • Symptoms • Change in disease status • Morbid events • Treatment-related morbidity</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: • With recurrent sinonasal polyposis who have undergone endoscopic sinus surgery</td>
<td>Interventions of interest are: • Implantable steroid-eluting sinus stents</td>
<td>Comparators of interest are: • Topical steroids alone</td>
<td>Relevant outcomes include: • Symptoms • Change in disease status • Morbid events • Treatment-related morbidity</td>
</tr>
</tbody>
</table>

Steroid-eluting sinus stents are devices used postoperatively following endoscopic sinus surgery (ESS) or for treatment of recurrent sinonasal polyposis following ESS. These devices maintain patency of the sinus openings in the postoperative period, and/or serve as a local drug delivery vehicle. Reducing postoperative inflammation and maintaining patency of the sinuses may be important in achieving optimal sinus drainage and may impact recovery from surgery and/or reduce the need for additional surgery.

For individuals who have chronic rhinosinusitis who have undergone ESS who receive implantable steroid-eluting sinus stents, the evidence includes RCTs. Relevant outcomes are symptoms, change in disease status, morbid events, and treatment-related morbidity. The most direct evidence relating to use of steroid-eluting nasal stents as an adjunct to ESS comes from 4 RCTs comparing steroid-eluting stents with either a non-steroid-eluting stent or medical management. The need for post-operative intervention at 30 days was reduced by 14% to 24%,
translating to a number needed to treat of 4.7 or more. Three trials used blinded assessors to evaluate post-implantation sinus changes, an important strength, but the trials had potentials for bias. To most accurately evaluate the benefit from PROPEL devices it is important to ensure that the comparison group is not undertreated (i.e., receives some form of packing, intranasal steroids, and irrigation). The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have recurrent sinonasal polyposis who have undergone endoscopic sinus surgery who receive implantable steroid-eluting sinus stents, the evidence includes RCTs. Relevant outcomes are symptoms, change in disease status, morbid events, and treatment-related morbidity. Two RCTs were identified evaluating the use of steroid-eluting nasal stents for recurrent or persistent nasal polyposis after ESS, which demonstrated improvements in polyp grade and ethmoid obstruction. Strengths of these trials included use of a sham control and adequate power for its primary outcome. However, the trials had a high risk of bias due to unblinded outcome assessment. Although avoidance of repeat ESS and oral steroids may be relevant outcomes for this indication, it would be more important if decisions about repeat ESS or other treatments were standardized and, in the trial setting, if decisions were prespecified or made by a clinician blinded to treatment group. Sinus stents may prove to have a role in nasal polyposis; however, further follow-up is needed to evaluate the durability of the results. The evidence is insufficient to determine the effects of the technology on health outcomes.

**BACKGROUND**

**Chronic Rhinosinusitis**

Chronic rhinosinusitis is an inflammatory sinus condition that has a prevalence between 1% and 5% in the U.S. population.1

**Treatment**

Endoscopic sinus surgery (ESS) is typically performed on patients with chronic rhinosinusitis unresponsive to conservative treatment. The surgery is associated with high rates of improvement in up to 90% of more appropriately selected patients. However, there are no high-quality randomized controlled trials comparing functional ESS with continued medical management or alternative treatment approaches. Because of the high success rates and minimally invasive approach, these procedures have rapidly increased in frequency, with an estimated 250,000 procedures performed annually in the United States.2 They can be done either in the physician’s office under local anesthesia or in the hospital setting under general anesthesia.

ESS involves the removal of small pieces of bone, polyps, and débridement of tissue within sinus cavities. There are a number of variations on the specific approach, depending on the disorders being treated and the preferences of the treating surgeon. For all procedures, there is substantial postoperative inflammation and swelling, and postoperative care is therefore a crucial component of ESS.
There are a number of postoperative treatment regimens, and the optimal regimen is uncertain. Options include saline irrigation, nasal packs, topical steroids, systemic steroids, topical decongestants, oral antibiotics, and/or sinus cavity débridement. Several randomized controlled trials have evaluated treatment options, but not all strategies have been rigorously evaluated. A 2011 systematic review has evaluated the evidence for these therapies. Reviewers concluded that the evidence was not strong for any of these treatments but that some clinical trial evidence supported improvements in outcomes. The strongest evidence supported use of nasal saline irrigation, topical nasal steroid spray, and sinus cavity débridement.

Some form of sinus packing is generally performed postoperatively. Simple dressings moistened with saline can be inserted manually following surgery. Foam dressings are polysaccharide substances that form a gel when hydrated and can be used as nasal packs for a variety of indications. Middle meatal spacers are splint-like devices that prop open the sinus cavities post-ESS, but are not designed for drug delivery. There is some randomized controlled trial evidence that middle meatal spacers may reduce the formation of synechiae following ESS, although the available studies have significant heterogeneity in this outcome.

Implantable Sinus Stents
Implantable sinus stents are another option for postoperative management following ESS. These implants are intended to stabilize the sinus openings and the turbinates, reduce edema, and/or prevent obstruction by adhesions. They can also be infused with medication delivered topically over an extended period of time, and this local delivery of medications may be superior to topical application in the postoperative setting.

Regulatory Status
Intraoperative Steroid-Eluting Sinus Stents
In 2011, the PROPEL(R) system (Intersect ENT, Menlo Park, CA) was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process (P100044). This device is a self-expanding, bioabsorbable, steroid-eluting stent intended for use in the ethmoid sinus. It is placed via endoscopic guidance using a plunger included with the device. Steroids (mometasone furoate) are released over an approximate duration of 30 days. The device dissolves over several weeks, and therefore does not require removal. In 2012, a smaller version of the PROPEL(R) device, the PROPEL(R) mini Sinus Implant, was approved for use in patients older than age 18 years following ethmoid sinus surgery. In 2017, the PROPEL Contour was approved through a PMA supplement. The PROPEL(R) Contour Sinus Implant is an adaptable implant that is designed to maximize drug delivery to the frontal and maxillary sinus.

Postoperative Steroid-Eluting Sinus Stents
SINUVA(TM) Sinus Implant (Intersect ENT, Inc., Menlo Park, CA) was initially approved in 1987. In 2017, the SINUVA(TM) Sinus Implant was approved with a new dose (1350 μg mometasone furoate) under a New Drug Application (NDA
209310). The corticosteroid is released over 90 days and the bioabsorbable polymers soften over this time. The implant is removed at Day 90 or earlier using standard surgical instruments. The SINUVA™ Sinus Implant is indicated for the treatment of nasal polyps in adult patients who have had ethmoid sinus surgery.

FDA product code: OWO

**Rationale**

This evidence review was created in July 2012 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through December 4, 2018.

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

RCTs are important in the evaluation of sinus implants as an adjunct to endoscopic sinus surgery (ESS) to adequately compare implantable stents with alternative treatment regimens and to minimize the effects of confounders on outcomes. Case series and trials without control groups offer little in the way of relevant evidence, because improvement in symptoms is expected after ESS and because there are multiple clinical and treatment variables that may confound outcomes.

**Steroid-Eluting Stents as an Adjunct to ESS**
Clinical Context and Therapy Purpose
The purpose of a steroid-eluting sinus stent in patients who have chronic rhinosinusitis who have endoscopic sinus surgery is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: does the adjunctive use of a steroid-eluting sinus stent improve the net health outcome in patients who have endoscopic sinus surgery?

The following PICOTS were used to select literature to inform this review.

Patients
The relevant population(s) of interest are patients who have endoscopic sinus surgery for chronic rhinosinusitis.

Interventions
The therapy being considered is a bioabsorbable steroid-eluting sinus stent (eg, PROPEL Sinus Stent, PROPEL mini Sinus Stent, PROPEL Countour Sinus Stent) for post-operative care following ESS.

Comparators
The most relevant comparison for sinus stents is unclear because there is no standardized optimal postoperative treatment regimen. Ideally, the “standard care” comparison group should include some form of packing, intranasal steroids, and irrigation. An important consideration in evaluating controlled trials is that the control arm may not be treated with optimal intensity, thereby leading to a bias in favor of the device. For example, a study design that compares a steroid-eluting stent with a non-steroid-eluting stent will primarily evaluate the efficacy of steroids when delivered by the device, but will not evaluate the efficacy of a stent itself. If the control group does not receive topical or oral steroids postoperatively, then this might constitute undertreatment in the control group and result in a bias favoring the treatment group. Another concern is comparison of the efficacy of a drug with the efficacy of a drug delivery system. For example, if a steroid-eluting spacer is compared with a control of saline irrigation alone, it will be difficult to separate the efficacy of the drug itself (steroids) from the drug delivery system (stent).

Outcomes
The Perioperative Sinus Endoscopy score sums the combined scores determined from middle turbinate position, middle meatal status, ethmoid cavity appearance, as well as secondary sinus blockage (frontal and sphenoid). Each category is scored from 0-2, with 0 being not present, 1 as partially present, and 2 being fully present. The highest total score is 16, with scores ranging from 18-20 when the frontal and sphenoid sinuses are also included. The higher the score, the worse the status of the nasal cavity.
Post-ESS synechiae formation, the Sino-Nasal Outcome Test (SNOT-22) Questionnaire and the Rhinosinusitis Disability Index may also be used to evaluate perioperative outcomes.

A beneficial outcome would be an improvement in symptoms. A harmful outcome would be adverse events from the implantable stents.

**Timing**
The PROPEL series of sinus stents are bioabsorbable and elute steroids for 30 days. Therefore, outcomes should be assessed within 30 days.

**Setting**
The setting is treatment by an otolaryngologist in a surgical center.

**Review of Evidence**
The literature consists of randomized trials, single-arm case series, and systematic reviews of these studies. The following is a summary of the key findings to date.

**Systematic Reviews**
A 2015 Cochrane review addressed steroid-eluting sinus stents for improving chronic rhinosinusitis (CRS) symptoms in individuals undergoing ESS. Study eligibility criteria were RCTs that compared the effects of steroid-eluting sinus stents with non-steroid-eluting sinus stents, nasal packing, or no treatment in adults with CRS who underwent ESS. After an initial search, 21 RCTs were identified, including the RCTs reported by Murr et al (2011) and Marple et al (2012) (described above). None of the trials met authors’ inclusion criteria. Reviewers concluded that there was no evidence from high-quality RCTs to demonstrate the benefits of steroid-eluting stents.

**Randomized Controlled Trials**
RCTs are shown in Tables 1 and 2. There are 4 RCTs of the PROPEL, PROPEL mini, and PROPEL Contour steroid-eluting sinus stents, all sponsored by the device manufacturer (Intersect ENT). These trials used an intrapatient control design, with each patient receiving a drug-eluting stent on 1 side and a non-drug-eluting stent or medical treatment on the other via random assignment.

The two trials of PROPEL for the ethmoid sinus had similar designs. Both compared an implant that is steroid-eluting with an identical non-steroid-eluting implant. Thus these trials tested the value of drug delivery via a stent, but did not test the value of a stent itself vs treatment without a stent. The primary efficacy outcome in Murr et al was degree of inflammation rated by the treating physician. In Marple et al the primary outcome was reduction in the need for postoperative interventions at day 30 postprocedure. A panel of 3 independent experts, blinded to treatment assignment and clinical information, viewed the endoscopic results and determined whether an intervention was indicated. The need for postoperative intervention by expert judgment was found in 33.3% of patients in the steroid-eluting arm and in 46.9% in the non-steroid-eluting arm.
The reduction in interventions was primarily driven by a 52% reduction in lysis of adhesions (p=0.005). The primary safety hypothesis was met, because there were no cases of clinically significant increases in ocular pressure recorded over the 90-day period postprocedure.

The RCTs by Smith et al (2016) and Luong et al (2017), implanted either a PROPEL Mini Sinus Implant or a PROPEL Contour Sinus Implant in the frontal sinus with a control of surgery alone on the contralateral side. The primary outcome was the need for post-operative intervention (eg, surgery or steroids) determined by an independent blinded physician. Both trials showed a reduction in the need for additional surgical intervention by approximately 22%, with no adverse effects of treatment. The number needed to treat was 4.7 to prevent 1 patient from undergoing postoperative intervention. No stent-related adverse events were noted.

**Table 1. Summary of Key RCT Characteristics**

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
<th>Active</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murr et al (2011)</td>
<td></td>
<td></td>
<td></td>
<td>38 patients with refractory CRS</td>
<td>Unilateral PROPEL steroid-eluting stent in the ethmoid sinus</td>
<td>Non-drug-eluting stent on the other contralateral side</td>
<td></td>
</tr>
<tr>
<td>Marple et al (2012)</td>
<td></td>
<td></td>
<td></td>
<td>105 patients with refractory CRS</td>
<td>Unilateral PROPEL steroid-eluting stent in the ethmoid sinus</td>
<td>Non-drug-eluting stent on the contralateral side</td>
<td></td>
</tr>
<tr>
<td>Smith et al (2016)</td>
<td>US</td>
<td>11</td>
<td></td>
<td>80 patients with CRS who were scheduled to undergo primary or revision bilateral frontal sinusotomy</td>
<td>Unilateral PROPEL Mini Sinus Implant in the frontal sinus</td>
<td>Surgery alone on the contralateral side</td>
<td></td>
</tr>
</tbody>
</table>
Luong et al (2017)\textsuperscript{13.}

US 12 80 patients with CRS who were scheduled to undergo primary or revision bilateral frontal sinusotomy

Unilateral PROPEL Contour Sinus Implant in the frontal sinus

Surgery alone on the contralateral side

CRS: chronic rhinosinusitis; RCT: randomized controlled trial.

**Table 2. Summary of Key RCT Results**

<table>
<thead>
<tr>
<th>Study</th>
<th>Primary Outcome Measure</th>
<th>Polypoid Changes</th>
<th>Adhesions/scarring</th>
<th>Implant-Related Adverse Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murr et al (2011)\textsuperscript{10.}</td>
<td><em>Degree of Inflammation at 21 Days Post-Procedure (100 mm VAS)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>37</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROPEL steroid-eluting Stent</td>
<td></td>
<td>18.4%</td>
<td>5.3%</td>
<td></td>
</tr>
<tr>
<td>Non-steroid-eluting stent</td>
<td></td>
<td>36.8%</td>
<td>21.1%</td>
<td></td>
</tr>
<tr>
<td>Diff</td>
<td>18 points</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>NR</td>
<td>0.039</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Marple et al (2012)(^{11})</td>
<td><strong>Need for Post-Operative Intervention Determined by 3 Independent Reviewers</strong></td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>N</td>
<td>91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROPEL steroid-eluting Stent</td>
<td>33.3%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Non-steroid-eluting stent</td>
<td>46.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diff</td>
<td>13.6%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>p-value</td>
<td>0.028</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smith et al (2016)(^{12})</th>
<th><strong>Need for Post-Operative Intervention at 30 Days (Independent Reviewer) n (%)</strong></th>
<th><strong>Need for Post-Operative Intervention at 90 Days</strong></th>
<th><strong>Occlusion/Restenosis Rate at Day 30</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>67 (adequate video for independent review)</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>PROPEL mini-sinus steroid-eluting stent</td>
<td>26 (38.8%)</td>
<td>16 (21.1%)</td>
<td>none</td>
</tr>
<tr>
<td>SOC without a stent</td>
<td>42 (62.7%)</td>
<td>35 (46.1%)</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>0.007</td>
<td>0.013</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Luong et al (2017)\textsuperscript{13}.

<table>
<thead>
<tr>
<th>Need for Post-Operative Intervention at 30 Days (Independent Reviewer)</th>
<th>n (%)</th>
<th>Need for Surgical Intervention at 30 Days (Independent Reviewer)</th>
<th>n (%)</th>
<th>Occlusion/Restenosis Rate at Day 90</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROPEL Contour steroid-eluting stent</td>
<td>7 (11.5)</td>
<td>4 (6.9)</td>
<td>16 (23.2)</td>
<td></td>
</tr>
<tr>
<td>SOC without a stent</td>
<td>20 (32.8)</td>
<td>15 (25.9)</td>
<td>28 (40.6)</td>
<td></td>
</tr>
<tr>
<td>Diff (95% CI)</td>
<td>21.3% (35.1% to 7.6%)</td>
<td>19.0% (32.8% to 5.1%)</td>
<td>−17.4% (−28.6% to −6.1%)</td>
<td></td>
</tr>
<tr>
<td>NNT</td>
<td>4.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>Range 13.6% to 23.9%</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

CI: confidence interval; HR: hazard ratio; NNT: number needed to treat; NR: not reported; RCT: randomized controlled trial; SOC: standard of care.

Gaps in relevance and in design and conduct are shown in Tables 3 and 4. The primary gap for the Studies by Murr et al (2011) and Marple et al (2012) on the PROPEL implant in the ethmoid sinus was whether the comparator had received the optimal treatment in terms of packing, intranasal steroids, and irrigation. For the studies by Smith et al (2016) and Luong et al (2017), there was a high percentage of patients who were not able to be evaluated due to video quality.
### Table 3. Relevance Gaps

<table>
<thead>
<tr>
<th>Study</th>
<th>Populationa</th>
<th>Interventionb</th>
<th>Comparatorc</th>
<th>Outcomesd</th>
<th>Follow-Up(\ast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murr et al (2011)(^{10})</td>
<td></td>
<td></td>
<td>3. The comparator may not have received the optimal treatment (some form of packing, intranasal steroids, and irrigation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marple et al (2012)(^{11})</td>
<td></td>
<td></td>
<td>3. The comparator may not have received the optimal treatment (some form of packing, intranasal steroids, and irrigation)</td>
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<tr>
<td>Smith et al (2016)(^{12})</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Luong et al (2017)(^{13})</td>
<td></td>
<td></td>
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</tbody>
</table>

The evidence gaps stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

- **Population key:**
  1. Intended use population unclear;
  2. Clinical context is unclear;
  3. Study population is unclear;
  4. Study population not representative of intended use.

- **Intervention key:**
  1. Not clearly defined;
  2. Version used unclear;
  3. Delivery not similar intensity as comparator;
  4. The intervention of interest.

- **Comparator key:**
  1. Not clearly defined;
  2. Not standard or optimal;
  3. Delivery not similar intensity as intervention;
  4. Not delivered effectively.

- **Outcomes key:**
  1. Key health outcomes not addressed;
  2. Physiologic measures, not validated surrogates;
  3. No CONSORT reporting of harms;
  4. Not establish and validated measurements;
  5. Clinical significant difference not prespecified;
  6. Clinical significant difference not supported.

- **Follow-Up key:**
  1. Not sufficient duration for benefit;
  2. Not sufficient duration for harms.

### Table 4. Study Design and Conduct Gaps

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation(a)</th>
<th>Blinding(b)</th>
<th>Selective Reporting(c)</th>
<th>Data Completeness(d)</th>
<th>Power(e)</th>
<th>Statistical(f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murr et al</td>
<td></td>
<td>3. Outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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\(^{a}\) Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

\(^{b}\) Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. The intervention of interest.

\(^{c}\) Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

\(^{d}\) Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

\(^{e}\) Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Details</th>
<th>Evidence Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2011)(^{10})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marple et al (2012)(^{11})</td>
<td>assessed by treating physician</td>
<td></td>
</tr>
<tr>
<td>Smith et al (2016)(^{12})</td>
<td>2. Incomplete reporting of secondary outcomes</td>
<td>1. 12 (17%) patients did not have independent review at 30 days due to suboptimal video quality.</td>
</tr>
<tr>
<td>Luong et al (2017)</td>
<td></td>
<td>1. 19 (24%) patients did not have independent review at 30 days due to suboptimal video quality.</td>
</tr>
</tbody>
</table>

The evidence gaps stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

d Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).
e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.
f Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

**Nonrandomized Comparative Studies**

The largest nonrandomized study identified was reported by Xu et al (2016).\(^{14}\). It evaluated post-ESS synechiae formation among 146 patients (252 nasal cavities) treated with a steroid-eluting absorbable spacer and 128 patients (233 nasal cavities) treated with a nonabsorbable spacer. Eligible patients included those who underwent ESS (at minimum, maxillary antrostomy and anterior ethmoidectomy) for CRS with or without nasal polyps and were treated with a sinus spacer. Rates of synechiae formation at 1 month postoperatively did not differ significantly
between groups (5 [2.0%] nasal cavities in the absorbable stent group vs 13
[5.6%] nasal cavities in the nonabsorbable spacer group).

**Section Summary: Steroid-Eluting Stents as an Adjunct to ESS**

The most direct evidence relating to use of steroid-eluting nasal stents as an adjunct to ESS comes from 4 RCTs comparing steroid-eluting stents with either a non-steroid-eluting stent or medical management. The need for post-operative intervention at 30 days was reduced by 14% to 24%, translating to a number needed to treat of 4.7 or more. Three trials used blinded assessors to evaluate postimplantation sinus changes, an important strength, but the trials had potentials for bias. To most accurately evaluate the benefit from PROPEL devices it is important to ensure that the comparison group is not undertreated (ie, receives some form of packing, intranasal steroids, and irrigation).

**Steroid-Eluting Stents for Recurrent Polyposis**

**Clinical Context and Therapy Purpose**

The purpose of steroid-eluting stents in patients who have recurrent polyposis is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: does the use of steroid-eluting stents improve the net health outcome in patients with recurrent polyposis?

The following PICOTS were used to select literature to inform this review.

**Patients**

The relevant population of interest are patients with recurrent polyposis after ESS.

**Interventions**

The therapy being considered is steroid-eluting stent (eg, SINUVA). This stent is bioresorbable and softens over time, but needs to be removed by 90 days.

**Comparators**

A sham treatment may be used to determine whether active treatment reduces the need for ESS.

**Outcomes**

The general outcomes of interest are symptoms, anatomic outcomes, and need for additional ESS. These outcomes may be measured by the nasal obstruction/congestion score change (scale 0–3), polyp grade change (scale 0 to 8), ethmoid sinus obstruction change (scale 0–100), and the percentage of patients still indicated for repeat sinus surgery.

A beneficial outcome would be an improvement in symptoms and reduction in repeat ESS.
A harmful outcome would be adverse events from the implantable stents.

**Timing**
The steroid-eluting stents are kept in place for up to 90 days. Relevant outcomes would be measured at 90 days to evaluate the short-term effects of the treatment and at one or two years to evaluate the durability of this treatment.

**Setting**
The setting is outpatient care by an otolaryngologist.

**Review of Evidence**
Two sham-controlled RCTs (RESOLVE and RESOLVE II) with a total of 400 patients have addressed outcomes after placement of steroid-eluting absorbable sinus stents in the office setting due to recurrent or persistent nasal polyposis after ESS (see Tables 5 and 6).\(^{15,16}\)

In RESOLVE, for endoscopically measured outcomes, at 90 days of follow-up, the treatment group had a greater reduction in polyp grade than the control group (-1.0 vs -0.1; p=0.016) and a greater reduction in percent ethmoid obstruction on a 100-mm VAS (-21.5 mm vs 1.3 mm; p=0.001), both respectively. For patient-reported outcomes, there were no significant differences in change in nasal obstruction/congestion scores between groups. In RESOLVE II the implant group showed significant reductions in nasal congestion, polyp grade, and ethmoid obstruction at 90 days compared to sham controls. Out of 200 patients treated with the implant, 39% were indicated for sinus surgery at 3 months compared to 63.3% of controls (p<0.001)

### Table 5. Summary of Key RCT Characteristics

<table>
<thead>
<tr>
<th>Study; Trial</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Active Comparator</td>
</tr>
<tr>
<td>Study</td>
<td>Patients</td>
<td>Intervention</td>
<td>Outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>--------------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Han et al (2014)(^{15}); RESOLVE</td>
<td>100</td>
<td>Placement of a mometasone-eluting nasal stent</td>
<td>53 patients who received office-based placement of a mometasone-eluting nasal stent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kern et al (2018)(^{16}); RESOLVE II</td>
<td>300</td>
<td>Insertion and removal of implants</td>
<td>201 patients who received a SINUVA(TM) mometasone-eluting bioabsorbable nasal stent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ESS: endoscopic sinus surgery; RCT: randomized controlled trial.
Table 6. Summary of Key RCT Results

<table>
<thead>
<tr>
<th>Study</th>
<th>Nasal obstruction/congestion score change (scale 0–3)</th>
<th>Change in Polyp Grade at 90 Days (scale 0 to 8)</th>
<th>Reduction in Ethmoid Obstruction (scale 100) at 90 Days</th>
<th>Patients Indicated for Sinus Surgery at 3 months n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Han et al (2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug-eluting nasal stent</td>
<td>-1.0</td>
<td>-21.5 mm</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Sham</td>
<td>-0.1</td>
<td>1.3 mm</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>P-value</td>
<td>0.016</td>
<td>0.001</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>Kern et al (2018)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug-eluting nasal stent mean (SD)</td>
<td>-0.80 (0.73)</td>
<td>-0.56 (1.06)</td>
<td>-11.3 (18.1)</td>
<td>78/200 (39.0%)</td>
</tr>
<tr>
<td>Sham mean (SD)</td>
<td>-0.56 (0.62)</td>
<td>-0.15 (0.91)</td>
<td>-1.9 (14.4)</td>
<td>62/98 (63.3%)</td>
</tr>
<tr>
<td>Diff or OR (95% CI)</td>
<td>-0.23 (−0.39 to −0.06)</td>
<td>-0.35 (−0.60 to −0.09)</td>
<td>-7.96 (−12.10 to −3.83)</td>
<td>2.69 (1.63 to 4.44)</td>
</tr>
<tr>
<td>P-value</td>
<td>0.007</td>
<td>0.007</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

CI: confidence interval; NR: not reported; OR: odds ratio; RCT: randomized controlled trial.

Gaps in relevance and design and conduct are shown in Tables 7 and 8. A major limitation of the trials was the short duration of follow-up to determine the durability of the treatment. In addition, there is a potential for bias since outcomes were evaluated by the treating physician.
### Table 7. Relevance Gaps

<table>
<thead>
<tr>
<th>Study</th>
<th>Population&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Intervention&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Comparator&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Outcomes&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Follow-Up&lt;sup&gt;e&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Han et al (2014)&lt;sup&gt;15&lt;/sup&gt;; RESOLVE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. The 90 day follow-up is insufficient to evaluate the durability of this treatment.</td>
</tr>
<tr>
<td>Kern et al (2018)&lt;sup&gt;16&lt;/sup&gt;; RESOLVE II</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. The 90 day follow-up is insufficient to evaluate the durability of this treatment.</td>
</tr>
</tbody>
</table>

The evidence gaps stated in this table are those notable in the current review; this is not a comprehensive gaps assessment. Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.  

b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. The intervention of interest.  

 Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.  


### Table 8. Study Design and Conduct Gaps

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Blinding&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Selective Reporting&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Data Completeness&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Power&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Statistical&lt;sup&gt;f&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Han et al (2014)&lt;sup&gt;15&lt;/sup&gt;; RESOLVE</td>
<td></td>
<td>3. Outcomes were assessed by the treating physician</td>
<td></td>
<td></td>
<td></td>
<td>3. Statistics were not reported for some outcome measures.</td>
</tr>
<tr>
<td>Kern et al (2018)&lt;sup&gt;16&lt;/sup&gt;; RESOLVE</td>
<td></td>
<td>3. Polyp grade and sinus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The evidence gaps stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<table>
<thead>
<tr>
<th>a Allocation key</th>
<th>Allocation not randomly allocated; Allocation not concealed; Allocation concealment unclear; Inadequate control for selection bias.</th>
</tr>
</thead>
<tbody>
<tr>
<td>b Blinding key</td>
<td>Not blinded to treatment assignment; Not blinded outcome assessment; Outcome assessed by treating physician.</td>
</tr>
<tr>
<td>c Selective Reporting key</td>
<td>Not registered; Evidence of selective reporting; Evidence of selective publication.</td>
</tr>
<tr>
<td>d Data Completeness key</td>
<td>High loss to follow-up or missing data; Inadequate handling of missing data; High number of crossovers; Inadequate handling of crossovers; Inappropriate exclusions; Not intent to treat analysis (per protocol for noninferiority trials).</td>
</tr>
<tr>
<td>e Power key</td>
<td>Power calculations not reported; Power not calculated for primary outcome; Power not based on clinically important difference.</td>
</tr>
<tr>
<td>f Statistical key</td>
<td>Analysis is not appropriate for outcome type: Analysis is not appropriate for multiple observations per patient; Confidence intervals and/or p values not reported; Comparative treatment effects not calculated.</td>
</tr>
</tbody>
</table>

**Section Summary: Steroid-Eluting Stents for Recurrent Polyposis**

One RCT was identified evaluating the use of steroid-eluting nasal stents for recurrent or persistent nasal polyposis after ESS, which demonstrated improvements in polyp grade and ethmoid obstruction. Strengths of this trial included use of a sham control and adequate power for its primary outcome. However, the trial had a high risk of bias due to unblinded outcome assessment. Although avoidance of repeat ESS and oral steroids may be relevant outcomes for this indication, it would be more important if decisions about repeat ESS or other treatments were standardized and, in the trial setting, if decisions were prespecified or made by a clinician blinded to treatment group. Sinus stents may prove to have a role in nasal polyposis; however, additional positive results from well-designed RCTs are needed to confirm the results of the single available RCT.

**Summary of Evidence**

For individuals who have chronic rhinosinusitis who have undergone ESS who receive implantable steroid-eluting sinus stents, the evidence includes RCTs. Relevant outcomes are symptoms, change in disease status, morbid events, and treatment-related morbidity. The most direct evidence relating to use of steroid-eluting nasal stents as an adjunct to ESS comes from 4 RCTs comparing steroid-eluting stents with either a non-steroid-eluting stent or medical management. The need for post-operative intervention at 30 days was reduced by 14% to 24%, translating to a number needed to treat of 4.7 or more. Three trials used blinded assessors to evaluate postimplantation sinus changes, an important strength, but the trials had potentials for bias. To most accurately evaluate the benefit from PROPEL devices it is important to ensure that the comparison group is not undertreated (ie, receives some form of packing, intranasal steroids, and...
irrigation). The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have recurrent sinonasal polyposis who have undergone endoscopic sinus surgery who receive implantable steroid-eluting sinus stents, the evidence includes RCTs. Relevant outcomes are symptoms, change in disease status, morbid events, and treatment-related morbidity. Two RCTs were identified evaluating the use of steroid-eluting nasal stents for recurrent or persistent nasal polyposis after ESS, which demonstrated improvements in polyp grade and ethmoid obstruction. Strengths of these trials included use of a sham control and adequate power for its primary outcome. However, the trials had a high risk of bias due to unblinded outcome assessment. Although avoidance of repeat ESS and oral steroids may be relevant outcomes for this indication, it would be more important if decisions about repeat ESS or other treatments were standardized and, in the trial setting, if decisions were prespecified or made by a clinician blinded to treatment group. Sinus stents may prove to have a role in nasal polyposis; however, further follow-up is needed to evaluate the durability of the results. The evidence is insufficient to determine the effects of the technology on health outcomes.

SUPPLEMENTAL INFORMATION

Clinical Input From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 1 physician specialty society and 4 academic medical centers while this policy was under review in 2012. Input overall was mixed, without consensus among respondents. Some reviewers expressed support for use of these devices after endoscopic sinus surgery. Reviewers who supported use cited the randomized controlled trials reviewed in this review as the main source of evidence. Other reviewers did not support use in general following endoscopic sinus surgery, arguing that a subset of patients may benefit, but there was no consensus on which populations this subgroup would include.

Practice Guidelines and Position Statements
No guidelines or statements were identified.

U.S. Preventive Services Task Force Recommendations
Not applicable.
**Medicare National Coverage**
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

**Ongoing and Unpublished Clinical Trials**
A search of clinicaltrials.gov in February, 2019 did not identify any trials that would likely influence this review.

**REFERENCES**
12. Smith, TT, Singh, AA, Luong, AA, Ow, RR, Shotts, SS, Sautter, NN, Han, JJ, Stambaugh, JJ, Raman, AA. Randomized controlled trial of a bioabsorbable steroid-releasing implant in the frontal sinus opening. Laryngoscope, 2016 Jul 2;126(12). PMID 27363723

Billing Coding/Physician Documentation Information

0406T Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant (Deleted code 1/1/2019)

0407T Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant; with biopsy, polypectomy or debridement (Deleted code 1/1/2019)

31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)

31299 Unlisted procedure, accessory sinuses

J3490 Unclassified drugs (Sinuva)

J7401 Mometasone furoate sinus implant, 10 mcg

S1090 Mometasone furoate sinus implant, 370 micrograms (Deleted code 10/1/2019)

Additional Policy Key Words

N/A

Policy Implementation/Update Information

12/1/15 New policy; considered investigational.

5/1/16 “And for Recurrent Sinus Disease” added to title and investigational policy statement added for the use of sinus stents for recurrent sinonasal polyposis. Added Cat III CPT codes.

12/1/16 No policy statement changes.

12/1/17 No policy statement changes.

8/1/18 Policy updated with literature review through December 11, 2017; references 1 and 9 added. Policy statement unchanged.

12/1/18 No policy statement changes.

12/1/19 Title changed to reflect the currently available steroid-eluting stents. Policy statements unchanged. Included Sinuva. Added policy statement: “The use of drug-eluting sinus stents is considered investigational in all other conditions.”

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