I. **POLICY**

The use of implantable sinus stents for postoperative treatment following endoscopic sinus surgery and for treatment of recurrent sinonasal polyposis is considered investigational. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

**Policy Guidelines**
Sinus stents are defined as implantable devices that are specifically designed to improve patency and/or deliver local medication. These are distinguished from sinus packing and variations on packing devices that are routinely employed post-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 stents 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.

**Cross-reference:**
MP- 1.119 Balloon Sinuplasty for Treatment of Chronic Sinusitis
II. PRODUCT VARIATIONS

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

FEP PPO*

* Refer to FEP Medical Policy Manual MP-7.01.134 Implantable Sinus Stents for Postoperative Use Following Endoscopic Sinus Surgery. The FEP Medical Policy Manual can be found at: www.fepblue.org

III. DESCRIPTION/BACKGROUND

Sinus stents are devices that are used postoperatively following endoscopic sinus surgery (ESS). The intent of these devices is to maintain patency of the sinus openings in the postoperative period, and/or to 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.

Endoscopic sinus surgery (ESS) is typically performed in patients with chronic rhinosinusitis unresponsive to conservative treatment. The surgery is associated with improvements in symptoms in up to 90% of more appropriately selected patients. 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 U.S. 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 debridement of tissue within the sinus cavities. There are a number of variations on the specific approach, depending on the disorders that are being treated and the preferences of the treating surgeon. For all procedures, there is a substantial amount of 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 debridement. A number of RCTs have
evaluated various treatment options, but all different strategies have not been rigorously evaluated.\textsuperscript{2-5} A systematic review evaluated the evidence for these therapies.\textsuperscript{1} The authors of this review 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 was for use of nasal saline irrigation, topical nasal steroid spray, and sinus cavity debridement.

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.\textsuperscript{6} Middle meatal spacers are splint-like devices that prop open the sinus cavities post-ESS, but are not capable of drug delivery. There is some RCT evidence that middle meatal spacers may reduce the formation of synechiae following ESS, although the available studies have significant heterogeneity in this outcome.\textsuperscript{7}

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**

In August 2011, the PROPEL™ system (Intersect ENT, Palo Alto, CA) was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process. This device is a self-expanding, bioabsorbable, steroid-eluting stent that is intended for use in the ethmoid sinus. It is placed via endoscopic guidance using a plunger included with the device. Steroids (mometasone furoate) are embedded in a polyethylene glycol polymer, which allows sustained release of the drug over an approximate duration of 30 days. The device dissolves over a period of several weeks, and therefore does not require removal. In September 2012, a smaller version of the PROPEL device, the PROPEL mini Sinus Implant, was approved for use in patients older than age 18 years following ethmoid sinus surgery. FDA product code: OWO

In October 2011, the Relieva Stratus™ MicroFlow spacer, a balloon-based device that acts as a spacer and medication delivery system, was cleared for marketing by FDA through the 510(k) program for use postoperatively to maintain an opening to the sinuses for the first 14 days postoperatively. It is placed via a catheter under endoscopic guidance. This device is temporary and requires manual removal after 30 days, with implantation of a new device if needed. It is approved for infusion with saline, but not for use with other medications (e.g., steroids). This device is no longer marketed in the United States.
IV. RATIONALE

The most recent literature review is through January 13, 2017.

Randomized controlled trials (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.

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).

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

STEROID-ELUTING STENTS AS AN ADJUNCT TO ESS

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 (2011) and Marple (2012) and colleagues (described above). None of the trials met authors’ inclusion criteria. Reviewers concluded that there is no evidence from high-quality RCTs to demonstrate the benefits of steroid-eluting stents.
A systematic review of early postoperative care following ESS was published in 2011. Reviewers evaluated a number of postoperative regimens, including stents. Reviewers included 1 RCT by Cote et al (2010) and 2 nonrandomized studies. Some devices included in these studies are considered middle meatal spacers and are outside the scope of this evidence review. The overall level of evidence was judged as B (RCT with limitations). Reviewers concluded that topical steroids delivered by the “nonstandard” route required further study and that the results of current studies could not be extrapolated to larger populations. Based on this evidence, reviewers did not recommend use of stents, but considered them an option for postoperative care.

Han et al (2012) performed a meta-analysis of the 2 published RCTs assessing the PROPEL implant, both of which compared a steroid-eluting stent with a non-steroid-eluting stent. Trial results were combined at the patient level, with reanalysis of the endoscopy videos by a panel of 3 independent ear, nose, and throat experts. The combined results were that the steroid-eluting device reduced postoperative interventions by 35% (p<0.001), reduced lysis of adhesions by 51% (p<0.001), and reduced the need for oral steroids by 46% (p<0.001).

Randomized Controlled Trials
As noted, there are 2 RCTs of the PROPEL sinus implant. Both trials have similar designs and both were sponsored by the device manufacturer (Intersect ENT). Both compared an implant that is steroid-eluting and an identical implant that is not steroid-eluting. Thus these trials tested the value of drug delivery via a stent, but did not test the value of a stent itself versus treatment without a stent.

The first RCT was published in 2011 by Murr et al. Thirty-eight patients with refractory CRS were included in the efficacy evaluation, and an additional 5 patients were enrolled for a safety evaluation. An intrapatient control design was used, meaning that each patient received a drug-eluting stent on 1 side and a non-drug-eluting stent on the other via random assignment. Patients were not permitted to use topical or oral steroids for 30 days following the procedure. A 14-day course of antibiotics was given to all patients. The primary end point was the degree of inflammation recorded on follow-up endoscopy at day 21 postprocedure, as scored by a 100-mm visual analog scale (VAS). Semiquantitative grading was also performed for polypoid changes, middle turbinate position, and adhesions/synechiae. The clinicians recording the outcomes were the same physicians who treated the patients. One patient withdrew prior to study completion.

The difference in inflammation scores at 21 days significantly favored the steroid-eluting group. The estimated difference in scores from graphical representation was approximately 18 units on the 0 to 100 VAS. The percentage of patients having polypoid changes was 18.4% in the steroid-eluting group and 36.8% in the non-steroid-eluting group (p=0.039). Adhesions were also significantly less common in the steroid-eluting group (5.3% vs 21.1%, p=0.03). There were no significant differences in the appearance or position of the middle turbinate.
In 2012, Marple et al published results of the ADVANCE II trial, an RCT of the PROPEL sinus implant for 105 patients with CRS refractory to medical management. This trial also used an intrapatient control design, with each patient receiving a drug-eluting stent on 1 side and a non-drug-eluting stent on the other via random assignment. Patients were not permitted to use topical or oral steroids for 30 days following the procedure. A 14-day course of antibiotics was given to all patients. The primary efficacy 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 endoscopy results and determined whether an intervention was indicated. The primary safety end point was the absence of clinically significant increased ocular pressure through day 90.

Three (2.9%) patients were lost to follow-up, and 9 (8.6%) patients could not be evaluated because the video of the endoscopy could not be graded. Two patients had the device removed within 30 days of placement. Of the remaining patients, 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 (p=0.028). According to the judgments of the clinical investigators treating the patients, intervention was required in 21.9% of the steroid-eluting group and 31.4% of the non-steroid-eluting group (p=0.068). 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.

**Nonrandomized Comparative Studies**

The largest nonrandomized study identified was reported by Xu et al in 2016. 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. Synechiae-related outcomes were unavailable for 10 (6.8%) subjects in the absorbable spacer group and 9 (7.0%) subjects in the nonabsorbable spacer group due to lack of 1-month follow-up. 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).

**Noncomparative Studies**

In 2014, Matheny et al reported results from a single-arm case series that evaluated use of office-based placement of a mometasone-eluting absorbable stent (PROPEL device) within 7 days of ESS including bilateral ethmoidectomy. Eligible patients had CRS with or without nasal polyps and were treated by 1 of 3 surgeons. The surgical procedure was ESS with complete ethmoidectomy,
followed by packing with a chitosan-polyethylene glycol absorbable dressing. At outpatient follow-up scheduled 5 to 7 days postsurgery, patients underwent debridement of the ethmoid cavity with placement of the steroid-eluting stent. Twenty patients who underwent 40 stent placements were included. Complications included acute sinusitis in 2 patients between 2 and 4 weeks postsurgery. Sinuses were evaluated using video endoscopy by an independent reviewer using a 100-mm VAS and a standardized case report form described by Murr et al (2011). Ethmoid sinus inflammation was reduced from 25.6 at baseline to 18.9 at week 4 (p=0.034). The mean total Sino-Nasal Outcome Test–20 (SNOT-20) score was reduced (improved) from 42.8 at baseline to 18.4 at week 2 and 8.9 at week 4. The procedure was generally well tolerated.

ADVANCE (2011) was a prospective, multicenter, single-arm trial of placement of a mometasone-eluting absorbable stent in 50 patients who were scheduled to undergo ESS. As reported by Forwith et al (2011), the end points evaluated on follow-up endoscopies were the degree of inflammation scored on a 100-mm VAS and semiquantitative grading for polypoid changes, middle turbinate position, and adhesions. By day 7 postprocedure, the inflammation scores were in the “minimal” range and remained there for the rest of the time points. At 1 month, polypoid lesions were present in 10% of patients, adhesions in 1.1%, and middle turbinate lateralization in 4.4%. Scores on the SNOT-22 and the Rhinosinusitis Disability Index improved significantly in the first month postprocedure.

A 2001 case series reported on 23 patients with refractory rhinosinusitis who underwent ESS and were treated postoperatively with the Relieva Stratus MicroFlow Spacer Device infused with triamcinolone. Over 6 months, there were significant improvements on multiple sinus-related outcome measures such as the SNOT-20 and the Lund-MacKay CT (computed tomography) scan scores. No significant intraoperative or postoperative complications were reported.

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 2 RCTs comparing steroid-eluting stents with a non-steroid-eluting stent. One trial used blinded assessors to evaluate postimplantation sinus changes, an important strength, but the trials had potentials for bias. In addition, to most accurately evaluate the benefit from the PROPEL device, ensuring that the comparison group is not undertreated (i.e., receives some form of packing, intranasal steroids, and irrigation) is important.

STERROID-ELUTING STENTS FOR INRECURRENT POLYPOSIS
A relatively small body of literature has addressed outcomes after placement of steroid-eluting absorbable sinus stents in the office setting as a planned procedure post-ESS or due to recurrent or persistent nasal polyposis after ESS.
Han et al (2014) reported results from RESOLVE, a sham-controlled randomized trial evaluating the use of office-based placement of a mometasone-eluting nasal stent for patients with recurrent nasal polyposis after ESS. Eligible patients had CRS, had undergone prior bilateral total ethmoidectomy more than 3 months earlier, had endoscopically confirmed recurrent bilateral ethmoid sinus obstruction due to polyposis that was refractory to medical therapy, and were considered candidates for repeat surgery based on the judgment of the surgeon and patient. Patients and those who administered symptom questionnaires at follow-up visits were blinding to treatment group. The trial was powered to detect a between-group difference of at least a 0.6-point change in polyp grade from baseline, and at least a 1.0-point change in nasal obstruction/congestion score. One hundred subjects were randomized to treatment (n=53) or control (n=47). 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. Compared with controls, fewer treatment-group patients required oral steroids for ethmoid obstruction (11% vs 26%) and fewer treatment-group patients were indicated for sinus surgery at 3 months based on established criteria (47% vs 77%), although statistical comparisons were not reported.

Also in 2014, Lavigne et al reported results from a case series of 12 patients who underwent placement of an investigational mometasone-eluting absorbable stent described as similar to the PROPEL device, but with differences in stent structure to target obstructed sinuses, for recurrent nasal polyposis after ESS. Eligible patients had CRS and had undergone bilateral ethmoidectomy more than 90 days before enrollment, but had refractory polyposis on at least 1 side that was at least grade 2 on a 0- to 4-point scale. All implants were placed in the office setting. Average SNOT-22 scores (reported as a normalized value with a total possible score that could range from 0-5) changed from 2.19 at baseline to 1.48 at day 7 (p<0.027), and continued to demonstrate improvements by the 6-month follow-up. Mean bilateral polyp grade (clinician-assessed) improved from 4.5 at baseline to 2.8 at day 7 (p<0.003), with continued improvements through 6-month follow-up. No significant adverse events were reported.

Ow et al (2014) reported plasma mometasone and cortisol concentrations for 5 patients with recurrent polyposis after bilateral total ethmoidectomy who underwent placement of the same investigational device described by Lavigne et al. Plasma mometasone concentrations were in the undetectable range in 26 of 32 samples at 3, 7, 14, 21, and 30 days postimplant and undetectable in all samples at 21 and 30 days postimplant.

<table>
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<th>Policy Title</th>
<th>Implantable Sinus Stents for Postoperative Use Following Endoscopic Sinus Surgery and for Recurrent Sinus Disease</th>
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<td>Policy Number</td>
<td>MP-1.140</td>
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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 endoscopic sinus surgery (ESS) who receive implantable steroid-eluting sinus stents, the evidence includes 2 randomized controlled trials (RCTs), a number of observational studies, and systematic reviews of these studies. Relevant outcomes are symptoms, change in disease status, morbid events, and treatment-related morbidity. The most direct evidence comes from 2 RCTs comparing steroid-eluting sinus stents with non-steroid-eluting stents, both of which showed some benefit with steroid-eluting stents. However, these trials had some limitations, including risk of bias. In addition, because of the comparison groups used in both, these trials primarily evaluated the efficacy of topical steroids when delivered by an implanted device, and not the efficacy of the device versus standard care. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have recurrent sinonasal polyposis who receive implantable steroid-eluting sinus stents, the evidence includes 1 RCT and 1 single-arm study. Relevant outcomes are symptoms, change in disease status, morbid events, and treatment-related morbidity. The most direct evidence comes from the available RCT, which compared steroid-eluting stents plus topical steroids to steroids alone for individuals with recurrent polyposis after ESS. This trial had a high risk of bias due to unblinded outcome assessment. Although avoidance of repeat ESS and oral steroids may be a relevant outcome for this indication, it would be important for decisions about repeat ESS or other treatments to be standardized and prespecified or be made by a clinician blinded to treatment group. The evidence is insufficient to determine the effects of the technology on health outcomes.

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 through 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 (ESS). Reviewers who supported use cited the randomized controlled trials reviewed in this policy as the main source of evidence. Other reviewers did not support use in general following ESS, 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 (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

ONGOING AND UNPUBLISHED CLINICAL TRIALS
Some currently unpublished trials that might influence this review are listed in Table 1

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<td>Sinus Implants Following Surgical Opening of the Frontal Sinus for Chronic Sinusitis. A</td>
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<td></td>
<td>Randomized Blinded Controlled Stud</td>
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NCT: national clinical trial.
* Denotes industry-sponsored or cosponsored trial.

V. DEFINITIONS
N/A
VI. Benefit Variations

The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member’s individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member’s benefit information or contact Capital for benefit information.

VII. Disclaimer

Capital’s medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. Coding Information

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore not covered:

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IX. REFERENCES


Other Sources

### MEDICAL POLICY

<table>
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<tr>
<th>POLICY TITLE</th>
<th>IMPLANTABLE SINUS STENTS FOR POSTOPERATIVE USE FOLLOWING ENDOSCOPIC SINUS SURGERY AND FOR RECURRENT SINUS DISEASE</th>
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<tr>
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<td>CAC 5/31/16</td>
<td>Minor review. Added “recurrent sinus disease” to title. Added “for treatment of recurrent sinonasal polyposis” to the investigational policy statement for the use of sinus stents. References and rationale updated. Coding reviewed.</td>
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<tr>
<td>Administrative Update 11/22/16</td>
<td>Variation reformatting</td>
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