



**Subject:** **Obstructive Sleep Apnea (OSA):  
Surgical-Management\***

**Effective Date:** **January 22, 2008**

**Department(s):** **Utilization Management**

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**Policy:** The procedures and treatment modalities listed in this policy are reimbursable in the management of OSA when criteria in the policy are met.

**Objective:** To ensure proper and consistent reimbursement and to delineate coverage of procedures for management of a specific medical problem.

**Procedure:** To be eligible for any of the procedures covered by this policy the individual must have OSA to a degree for which continuous positive airway pressure (CPAP) is reimbursable **AND** be unable to tolerate or comply with CPAP. (Please see the Policy on CPAP.)

A. The presence of obstructive sleep apnea (ICD-9 327.23; **ICD-10 G47.33**) must be documented. Appropriate documentation of obstructive sleep apnea includes but is not limited to:

1. Clinical information: history (witnessed apneic episodes, daytime somnolence, cardiac problems related to insomnia); if obese, documentation of measures taken for weight loss
2. Physical examination: height, weight, otolaryngologic evaluation
3. Sleep study: actual report as well as summary (see Policy, Sleep Disordered Breathing Testing.)

B. CPAP will be considered medically necessary if there is documentation of obstructive sleep apnea (OSA) with any one of the following:

1. Respiratory Distress Index (Apnea-Hypopnea Index [AHI]) >15
2. AHI 5 – 14 with clinical history and examination suggestive of OSA and with either oxygen saturations <85% or cardiac arrhythmias documented during sleep study
3. AHI 5 – 14 with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke
4. Obstructive apneic episodes more frequent than 5 times per hour with  $\geq 20$  second pauses
5. Upper airway resistance syndrome with all of the following characteristics:
  - a. Excessive daytime sleepiness documented by history
  - b. AHI <5
  - c. Greater than five snoring-related arousals from sleep per hour during Polysomnography

C. Other positive airway pressure modalities, such as bilevel positive airway pressure (BPAP) with or without a humidifier, without a back-up respiratory rate (**HCPCS E0601, E0651, E0652**) for the treatment of coexistent obstructive sleep apnea and central hypoventilation, or for an individual who is intolerant of required high pressure CPAP will be authorized if they meet the above criteria for CPAP. Auto Bi-level therapy (HCPCS E0470) will be authorized for an individual with documented trial and failure of CPAP. BPAP with a back-up respiratory rate (HCPCS E0471, E0472) will be authorized when treatment-emergent central sleep apnea is documented on polysomnography with positive airway pressure.

D. Initially, a CPAP or BiPAP device will be rented for 3 months. For further use, an update from the attending physician is required, documenting efficacy and compliance. If efficacy and compliance

are documented, and ongoing use is anticipated, the CPAP device will be approved for purchase. Compliance is defined as use of the device  $\geq 4$  hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. Purchase will also be approved for replacement of a non-functioning device previously in use with documented compliance.

E. The following interfaces for use with positive airway pressure devices are approvable and replaceable at a frequency of no more often than every three months:

- nasal mask (HCPCS code A7027)
- nasal pillows/prongs (HCPCS code A7034)
- full face mask (HCPCS code A7030)
- Oracle™ Oral Mask(HCPCS code A7044)

F. For those members who cannot tolerate or comply with CPAP, BiPAP , the following modalities of management of OSA are reimbursable:

The following procedures for the surgical management of OSA are reimbursable:

1. Uvulopalatopharyngoplasty (**UPPP, CPT 42145**)
2. Laser assisted uvulopalatopharyngoplasty (**LAUP, HCPCS S2080**) only in individuals who have other medical conditions that preclude UPPP and who have failed or cannot tolerate CPAP
3. Custom-fitted and prefabricated oral appliances to reduce upper airway collapsibility (**E0485, E0486**)
4. Tracheotomy (**31600**) when all other measures have failed to correct OSA
5. Jaw realignment surgery including but not limited to the following, when other measures have failed:
  - i. Hyoid myotomy and suspension (**21685**)
  - ii. Mandibular osteotomy with genioglossus advancement (**21199**)
6. In children, tonsillectomy and adenoidectomy (**42820 – 42826; 42830-42836**) are reimbursable as treatment for OSA.

- F. The following are **NOT** reimbursable, as there is not a satisfactory body of peer-reviewed literature documenting their efficacy in the management of OSA and they are thus deemed experimental, investigational, and unproven:
1. Somnoplasty (**41530**)
  2. Injection snoreplasty
  3. Cautery-assisted palatal stiffening operation (CAPSO)
  4. Pillar™ palatal implant system
  5. Flexible positive airway pressure
  6. Provent™ nasal device(expiratory positive airway pressure)
  7. Cervical pillow positioning devices( Zzoma and Sona positioning devices)
  8. Oral negative pressure therapy(Winx® device)
  9. Atrial overdrive pacing
  10. Electrosleep therapy
  11. Tongue-base suspension( AIRVance system)
  12. Hypoglossal nerve stimulation devices( e.g. Inspire II Upper Airway Stimulation)
  13. Transpalatal advancement pharyngoplasty
  14. CPAP PRO® mouthpiece nasal insert interface for positive airway pressure therapy

**NOTE:** This policy replaces the policy on Laser Assisted Uvulopalatoplasty and integrates criteria in the CPAP policy which it augments and replaces.

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CPAP Policy History:

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OSA Treatment Policy History:

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\*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.