



## Sleep Apnea (Obstructive and Central) – Surgical

Last Revision/Review Date: January 20, 2021

P&P # C.5.04

### Policy

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

### Procedure

#### A. Documentation Required:

In order to facilitate the authorization process referral requests for **Uvulopalatopharyngoplasty (UPPP)** surgical treatment must include **ALL** the following:

1. Physical exam including detailed description of the oral-pharynx cavity;
2. Documentation of physical or physiological functional deficits related to upper airway obstruction;
3. Patient comorbidities which may be impacted by the requested procedure;
4. Documentation of CPAP trial;
5. Results of polysomnography testing;
6. Results of laryngoscopy;
7. Practitioner statement of how the patient's symptoms will be measurably resolved by the requested surgical or invasive procedure.

In order to facilitate the authorization process referral requests for **Hypoglossal Nerve Stimulation** implantation must include **ALL** the following:

1. Physical exam including detailed description of the oral-pharynx cavity;
2. Documentation of physical or physiological functional deficits related to upper airway obstruction;
3. Documentation of prior surgeries or radiation therapy of the mouth, throat, tongue or larynx and a statement from the physician placing the device explaining why this history does not preclude effective treatment with the device;
4. Patient comorbidities which may be impacted by the requested procedure;
5. Documentation of CPAP trial;
6. Results of polysomnography testing;
7. Results of endoscopy performed during drug-induced sleep showing non-concentric soft palate collapse;
8. Patients of childbearing age must have documentation that the patient is not pregnant or planning to become pregnant and the patient has been informed that hypoglossal nerve stimulation is contraindicated in pregnancy.

9. Statement from a board-certified Sleep Medicine Physician or APP working in collaboration with such Physician of how the patient's symptoms will be measurably resolved by the requested invasive procedure;
10. Physician placing device has prior experience placing devices through fellowship training or training course by the device manufacturer;
11. Patient has access to Sleep physicians and technicians who are knowledgeable in device programming and management.

**B. Criteria for Medical Necessity:**

Uvulopalatopharyngoplasty (UPPP) surgical treatment for OSA is considered to be medically necessary if **ALL** of the following criteria are met:

1. Patient meets criteria for CPAP within the past two (2) years. See Medical Policy C.11.06 *Sleep Apnea (Obstructive and Central) - Non-Surgical Treatment*; **AND**
2. Documented intolerance to CPAP despite reasonable attempts with multiple mask trials over at least 30 days; **AND**
3. Patient's oropharynx shows evidence of redundant/patulous lateral pharyngeal folds on laryngoscopy; **AND**
4. Noted absence of laryngeal/hypopharyngeal lesions on laryngoscopy.

Hypoglossal Nerve Stimulation (HGNS) (e.g., Inspire®) for OSA with an FDA approved device is considered medically necessary if **ALL** of the following criteria are met:

1. Patient is 18 years of age or older; **AND**
2. Has been diagnosed with **ONE** of the following conditions as determined by a diagnostic procedure outlined in Medical Management Policy C.11.06 *Sleep Apnea (Obstructive and Central) – Non-Surgical* performed within the past two (2) years:
  - a. Severe obstructive sleep apnea with an overall Apnea-Hypopnea Index (AHI), Respiratory Disturbance Index (RDI), or Respiratory Event Index (REI) of  $\geq 30$ ; **OR**
  - b. Moderate obstructive sleep apnea with an overall AHI, RDI or REI of 15-29; **AND**
3. Documented intolerance to or failure of CPAP despite reasonable attempts with multiple (2 or more) mask trials over at least 30 days; **AND**
4. Patients with moderate obstructive sleep apnea must also meet the requirements for an oral appliance as outlined in Medical Policy C.11.06 *Sleep Apnea (Obstructive and Central)-Non-Surgical* with documented failure of the oral appliance for treatment of OSA defined as a diagnostic procedure showing AHI  $\geq 15$  while the oral appliance is in use; **AND**
5. Patient BMI is less than 32 kg/m<sup>2</sup>; **AND**
6. Patient does not have central plus mixed apneas > 25% of total AHI; **AND**
7. Patient does NOT have complete concentric collapse of the soft palate as seen during drug-induced sleep endoscopy (DISE); **AND**
8. Patient does not have other anatomical abnormalities that would prevent effective use of the device, (i.e., tonsillar hypertrophy, history of surgical resections or radiation therapy treatment for cancer of the larynx, tongue or throat without physician statement addressing why these do not preclude effective device use); **AND**
9. Patient is NOT pregnant or planning to become pregnant (see documentation requirements above) **AND**

10. Patient is cognitively and physically able to self-operate the sleep remote or has reliable assistance to do so.

**C. Indications Considered Experimental and Investigational:**

*(Not all inclusive)*

1. The following surgical procedures are unproven for treating OSA:
  - a. Cold knife uvulectomy and laser assisted uvuloplasty (LAUP, laser uvulectomy)
  - b. Radiofrequency volumetric tissue reduction (RFVTR) of the soft palate, uvula, or tongue base (e.g., Coblation®, Somnoplasty®);
  - c. Palatal implants (e.g., Pillar®);
  - d. Lingual suspension (e.g., AIRvance™ Tongue Suspension (formerly Repose®) – also referred to as tongue stabilization, tongue stitch or tongue fixation;
  - e. Transoral robotic surgery (TORS)
  
2. Uvulectomy alone is considered experimental and investigational as a treatment for obstructive sleep apnea.
  
3. Phrenic Nerve Stimulation (e.g., Remedē System) is considered experimental and investigational for treatment of CSA.

**D. Indications Considered Not Medically Necessary:**

1. Replacement of a Hypoglossal Nerve Stimulation (HGNS) (e.g., Inspire®) device, including leads, while it remains under warranty.

**CPT/HCPCS CODES:**

42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)
42140	Uvulectomy, excision of uvula
64568	Incision for implantation of cranial nerve (e.g. vagus nerve) neurostimulator electrode array & pulse generator
95970	Electronic analysis of implanted neurostimulator pulse generator system
0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator

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