Clinical Review Criteria Related to Laser-Assisted Uvulopalatoplasty or Uvulopalatopharyngoplasty

I. Criteria for Approval

A. Indications for Approval:

1. Unable to tolerate an oral appliance (not applicable with severe sleep apnea).
2. Unable to tolerate CPAP or BiPAP (e.g., CPAP ineffective or not tolerated).
3. No lesions documented by laryngoscopy and documentation of clinical conditions such as hypertension, ischemic heart disease and impaired cognition.

II. What is Not Covered

A. Laser-Assisted Uvulopalatoplasty (LAUP) is not covered at this time as it is not considered effective for Obstructive Sleep Apnea (CMS LCD 30731 Surgical Treatment of Obstructive Sleep Apnea)

B. Cautery-assisted palatal stiffening operation (CAPSO)

C. Pillar Palatal Implant System

D. Radiofrequency volumetric tissue reduction (RFVTR) of the soft palate, uvula, or tongue base (coblation, somnoplasty)

E. AIRvance system

F. Transpalatal advancement pharyngoplasty

G. Provent Professional Sleep Apnea Therapy Device

H. Electrosleep therapy

I. Injection snoreplasty
J. Atrial overdrive pacing

K. Indications for denial include, but may not be limited to:
   1. Requested for the treatment of snoring
   2. Course of nasal CPAP or BiPAP has not been tried, OR
   3. No record of sleep study being performed

Mild sleep apnea = The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events.

Severe sleep apnea = AHI greater than or equal to 30.

III. CPT/ICD-10/HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

ICD 10 Codes:

- G47.30 Sleep apnea unspecified
- G47.33 Obstructive sleep apnea

IV. References

NCQA Standard, UM2, Clinical Criteria for Utilization Management Decisions, Element A


Centers for Medicare and Medicaid Services. LCD for Surgical Treatment for Obstructive Sleep Apnea (OSA) (L30731) [Link](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34526&ver=8&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Massachusetts&KeyWord=surgical+treatment+OSA&KeyWordLookUp=Title&KeyWordSearchType=And&FriendlyError=NoLCDIDVersion&bc=gAAAABAAAAA%3d%3d& (Last Accessed 2/8/17)
For MassHealth –
Section 450.204 Definition of Medical Necessity
(Last Accessed 2/8/17)

Uvulopalatopharyngoplasty in the Management of Obstructive Sleep Apnea: The Mayo Clinic Experience. Khan, Akram, MD, Ramar, Kannan, MBBS, MD, Maddirala, Supriya, MD, Friedman, Oren, MD, Pallanch, John, MD, Olson, Eric, MD.
Mayo Clin Proc Sep 2009 84(9):795-800
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2735429
(Last Accessed 2/8/17)

Winifred S. Hayes, Inc., Sleep Apnea Treatment, Surgical: October 19, 2009
https://www.hayesinc.com/subscribers/subscriberArticlePDF.pdf?articleId=2336
(Last Accessed 2/8/17)

Laryngoscope 2003 July, 113(7) 1175-81
(Last Accessed 2/8/17)

V. Summary of Changes

06/29/2017
• Section I., Clinical Review Criteria, A., Indications for Approval, 3.: Removed “Moderate/Severe sleep apnea* by study”
• Section II. (What is Not Covered, K.): Changed from Moderate sleep apnea to Mild sleep apnea. Removed asterisks
• Added new disclaimer, updated references and last accessed dates

VI. Review Dates

HNE Review Dates: 9/10/13, 9/9/14, 9/8/15, 6/14/16, 5/9/17
MHI Review Dates: 01/01/14, 10/23/14, 10/07/15, 6/30/16, 06/29/2017

© 2014 Health New England
MHI-MS-MPLASERASSISTEDUVULOPALATOPLASTY-2017-06-29-ALL
Medical Guideline Disclaimer

The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical review criteria based upon a review of currently available clinical information (including, without limitation clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by Minuteman. If there is a discrepancy between this policy and a member’s benefit program, the benefit program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management, administrative and other services to its members.