



MASSACHUSETTS

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Medical Policy

Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome

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Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty, uvulopalatal flap, expansion sphincter pharyngoplasty, lateral pharyngoplasty, palatal advancement pharyngoplasty, relocation pharyngoplasty) may be considered **MEDICALLY NECESSARY** for the treatment of clinically significant obstructive sleep apnea (OSA) syndrome in appropriately selected adults who have failed an adequate trial of continuous positive airway pressure (CPAP) or failed an adequate trial of an oral appliance (OA). Clinically significant OSA is defined as those patients who have:

- Apnea/hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) 15 or more events per hour, or
- AHI or RDI 5 or more events and 14 or less events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

Hyoid suspension, surgical modification of the tongue, and/or maxillofacial surgery, including mandibular-maxillary advancement (MMA), may be considered **MEDICALLY NECESSARY** in appropriately selected adult patients with clinically significant OSA and objective documentation of hypopharyngeal obstruction

who have failed an adequate trial of continuous positive airway pressure (CPAP) or failed an adequate trial of an oral appliance (OA). Clinically significant OSA is defined as those patients who have:

- AHI or RDI 15 or more events per hour, or
- AHI or RDI 5 or more events and 14 or less events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

Adenotonsillectomy may be considered **MEDICALLY NECESSARY** in children (2 -18 years of age) with obstructive sleep apnea and hypertrophic tonsils as determined through patient history and clinical exam. A polysomnography is recommended in patients with sleep-disordered breathing in certain conditions¹, see below:

The American Academy of Otolaryngology - Head and Neck Surgery [Clinical Practice Guideline: Polysomnography for Sleep-Disordered Breathing Prior to Tonsillectomy in Children](#) recommends a polysomnography in the following clinical circumstances.

- The clinician should refer children with sleep-disordered breathing for polysomnography if they exhibit certain complex medical conditions such as obesity, Down syndrome, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidoses.
- The clinician should advocate for polysomnography prior to tonsillectomy for sleep-disordered breathing in children without any of the comorbidities listed in statement 1 for whom the need for surgery is uncertain or when there is discordance between tonsillar size on physical examination and the reported severity of sleep-disordered breathing.

Surgical treatment of OSA that does not meet the criteria above would be considered **NOT MEDICALLY NECESSARY**.

The following minimally-invasive surgical procedures are considered **INVESTIGATIONAL** for the sole or adjunctive treatment of obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS):

- Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues, AND
- Laser-assisted palatoplasty (LAUP) or radiofrequency volumetric tissue reduction of the palatal tissues, AND
- Palatal stiffening procedures including, but not limited to, cautery-assisted palatal stiffening operation, injection of a sclerosing agent, and the implantation of palatal implants,
- Tongue base suspension, AND
- All other minimally-invasive surgical procedures not described above.

Implantable hypoglossal nerve stimulators are considered **INVESTIGATIONAL** for all indications, including but not limited to the treatment of OSA.

All interventions, including LAUP, radiofrequency volumetric tissue reduction of the palate, or palatal stiffening procedures, are **NOT MEDICALLY NECESSARY** for the treatment of snoring in the absence of documented OSA. Snoring alone is not considered a medical condition.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care	Prior authorization is required for sleep apnea surgery (CPT

(HMO and POS)	<p>codes 42145, 21193-21199, 21206 and 21685).</p> <p>Prior authorization is not required for adenoidectomy and tonsillectomy procedures (CPT codes 42820-42821, 42825-42826, 42830-42831 and 42835-42836).</p>
Commercial PPO and Indemnity	<p>Prior authorization is not required for sleep apnea surgery, adenoidectomy or tonsillectomy.</p>
Medicare HMO BlueSM	<p>Prior authorization is required for sleep apnea surgery (CPT codes 42145, 21193-21199, 21206 and 21685).</p> <p>Prior authorization is not required for adenoidectomy and tonsillectomy procedures (CPT codes 42820-42821, 42825-42826, 42830-42831 and 42835-42836).</p>
Medicare PPO BlueSM	<p>Prior authorization is not required for sleep apnea surgery, adenoidectomy or tonsillectomy.</p>

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (e.g. Wassmund or Schuchard)
21685	Hyoid myotomy and suspension
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42820	Tonsillectomy and adenoidectomy; younger than age 12
42821	Tonsillectomy and adenoidectomy; age 12 or over
42825	Tonsillectomy, primary or secondary; younger than age 12
42826	Tonsillectomy, primary or secondary; age 12 or over
42830	Adenoidectomy, primary; younger than age 12
42831	Adenoidectomy, primary; age 12 or over
42835	Adenoidectomy, secondary; younger than age 12

42836	Adenoidectomy, secondary; age 12 or over
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ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
G47.30	Sleep apnea, unspecified
G47.33	Obstructive sleep apnea (adult) (pediatric)

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0CQ70ZZ	Repair Tongue, Open Approach
09QN0ZZ	Repair Nasopharynx, Open Approach
09QN3ZZ	Repair Nasopharynx, Percutaneous Approach
09QN4ZZ	Repair Nasopharynx, Percutaneous Endoscopic Approach
09QN7ZZ	Repair Nasopharynx, Via Natural or Artificial Opening
09QN8ZZ	Repair Nasopharynx, Via Natural or Artificial Opening Endoscopic
09RN0JZ	Replacement of Nasopharynx with Synthetic Substitute, Open Approach
09RN7JZ	Replacement of Nasopharynx with Synthetic Substitute, Via Natural or Artificial Opening
09RN8JZ	Replacement of Nasopharynx with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
09UN0JZ	Supplement Nasopharynx with Synthetic Substitute, Open Approach
09UN7JZ	Supplement Nasopharynx with Synthetic Substitute, Via Natural or Artificial Opening
09UN8JZ	Supplement Nasopharynx with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0CQ20ZZ	Repair Hard Palate, Open Approach
0CQ23ZZ	Repair Hard Palate, Percutaneous Approach
0CQ30ZZ	Repair Soft Palate, Open Approach
0CQ33ZZ	Repair Soft Palate, Percutaneous Approach
0CQ73ZZ	Repair Tongue, Percutaneous Approach
0CQ7XZZ	Repair Tongue, External Approach
0CQM0ZZ	Repair Pharynx, Open Approach
0CQM3ZZ	Repair Pharynx, Percutaneous Approach
0CQM4ZZ	Repair Pharynx, Percutaneous Endoscopic Approach
0CQM7ZZ	Repair Pharynx, Via Natural or Artificial Opening
0CQM8ZZ	Repair Pharynx, Via Natural or Artificial Opening Endoscopic
0CQN3ZZ	Repair Uvula, Percutaneous Approach
0CQNXZZ	Repair Uvula, External Approach
0CS20ZZ	Reposition Hard Palate, Open Approach
0CS30ZZ	Reposition Soft Palate, Open Approach
0CTP0ZZ	Resection of Tonsils, Open Approach
0CTQ0ZZ	Resection of Adenoids, Open Approach
0CU207Z	Supplement Hard Palate with Autologous Tissue Substitute, Open Approach
0CU20JZ	Supplement Hard Palate with Synthetic Substitute, Open Approach
0CU20KZ	Supplement Hard Palate with Nonautologous Tissue Substitute, Open Approach
0CU237Z	Supplement Hard Palate with Autologous Tissue Substitute, Percutaneous Approach
0CU23JZ	Supplement Hard Palate with Synthetic Substitute, Percutaneous Approach
0CU23KZ	Supplement Hard Palate with Nonautologous Tissue Substitute, Percutaneous Approach

0CU307Z	Supplement Soft Palate with Autologous Tissue Substitute, Open Approach
0CU30JZ	Supplement Soft Palate with Synthetic Substitute, Open Approach
0CU30KZ	Supplement Soft Palate with Nonautologous Tissue Substitute, Open Approach
0CU337Z	Supplement Soft Palate with Autologous Tissue Substitute, Percutaneous Approach
0CU33JZ	Supplement Soft Palate with Synthetic Substitute, Percutaneous Approach
0CU33KZ	Supplement Soft Palate with Nonautologous Tissue Substitute, Percutaneous Approach
0CUM07Z	Supplement Pharynx with Autologous Tissue Substitute, Open Approach
0CUM0JZ	Supplement Pharynx with Synthetic Substitute, Open Approach
0CUM0KZ	Supplement Pharynx with Nonautologous Tissue Substitute, Open Approach
0CUM77Z	Supplement Pharynx with Autologous Tissue Substitute, Via Natural or Artificial Opening
0CUM7JZ	Supplement Pharynx with Synthetic Substitute, Via Natural or Artificial Opening
0CUM7KZ	Supplement Pharynx with Nonautologous Tissue Substitute, Via Natural or Artificial Opening
0CUM87Z	Supplement Pharynx with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0CUM8JZ	Supplement Pharynx with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0CUM8KZ	Supplement Pharynx with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0NQT0ZZ	Repair Right Mandible, Open Approach
0NQT3ZZ	Repair Right Mandible, Percutaneous Approach
0NQT4ZZ	Repair Right Mandible, Percutaneous Endoscopic Approach
0NQTXZZ	Repair Right Mandible, External Approach
0NQV0ZZ	Repair Left Mandible, Open Approach
0NQV3ZZ	Repair Left Mandible, Percutaneous Approach
0NQV4ZZ	Repair Left Mandible, Percutaneous Endoscopic Approach
0NQVXZZ	Repair Left Mandible, External Approach
0NUT07Z	Supplement Right Mandible with Autologous Tissue Substitute, Open Approach
0NUT0JZ	Supplement Right Mandible with Synthetic Substitute, Open Approach
0NUT0KZ	Supplement Right Mandible with Nonautologous Tissue Substitute, Open Approach
0NUT37Z	Supplement Right Mandible with Autologous Tissue Substitute, Percutaneous Approach
0NUT3JZ	Supplement Right Mandible with Synthetic Substitute, Percutaneous Approach
0NUT3KZ	Supplement Right Mandible with Nonautologous Tissue Substitute, Percutaneous Approach
0NUT47Z	Supplement Right Mandible with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0NUT4JZ	Supplement Right Mandible with Synthetic Substitute, Percutaneous Endoscopic Approach
0NUT4KZ	Supplement Right Mandible with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0NUV0JZ	Supplement Left Mandible with Synthetic Substitute, Open Approach
0NUV0KZ	Supplement Left Mandible with Nonautologous Tissue Substitute, Open Approach
0NUV3JZ	Supplement Left Mandible with Synthetic Substitute, Percutaneous Approach
0NUV3KZ	Supplement Left Mandible with Nonautologous Tissue Substitute, Percutaneous Approach
0NUV4JZ	Supplement Left Mandible with Synthetic Substitute, Percutaneous Endoscopic Approach
0NUV4KZ	Supplement Left Mandible with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach

The following CPT and HCPCS codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
41512	Tongue base suspension, permanent suture technique
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session
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
0468T	Removal of chest wall respiratory sensor electrode or electrode array

HCPCS Codes

HCPCS codes:	Code Description
S2080	Laser-assisted uvulopalatoplasty (LAUP)

Description

Obstructive sleep apnea (OSA) is characterized by repetitive episodes of upper airway obstruction due to the collapse and obstruction of the upper airway during sleep. OSA is associated with a heterogeneous group of anatomic variants producing obstruction. In patients with OSA, the normal pharyngeal narrowing may be accentuated by anatomic factors, such as a short, fat “bull” neck, elongated palate and uvula, and large tonsillar pillars with redundant lateral pharyngeal wall mucosa. In addition, OSA is associated with obesity. OSA may also be associated with craniofacial abnormalities, including micrognathia, retrognathia, or maxillary hypoplasia. Obstruction anywhere along the upper airway can result in apnea.

The hallmark symptom of OSA is excessive daytime sleepiness, and the typical clinical sign of OSA is snoring, which can abruptly cease and be followed by gasping associated with a brief arousal from sleep. The snoring resumes when the patient falls back to sleep, and the cycle of snoring/apnea/arousal may be repeated as frequently as every minute throughout the night. Sleep fragmentation associated with the repeated arousal during sleep can impair daytime activity. For example, adults with OSA-associated daytime somnolence are thought to be at higher risk for accidents involving motorized vehicles (ie, cars, trucks, heavy equipment). OSA in children may result in neurocognitive impairment and behavioral problems. In addition, OSA affects the cardiovascular and pulmonary systems. For example, apnea leads to periods of hypoxia, alveolar hypoventilation, hypercapnia, and acidosis. This in turn can cause systemic hypertension, cardiac arrhythmias, and cor pulmonale. Systemic hypertension is common in patients with OSA. Severe OSA is associated with decreased survival, presumably related to severe hypoxemia, hypertension, or an increase in automobile accidents related to overwhelming sleepiness.

DIAGNOSIS

The diagnosis of OSA rests on a combination of clinical evaluation and objective criteria to identify those levels of obstruction considered to be clinically significant MP #529. The criterion standard diagnostic test for sleep disorders is polysomnography, which includes sleep staging to assess arousals from sleep, and determination of the frequency of apneas and hypopneas from channels measuring oxygen desaturation, respiratory airflow, and respiratory effort. An obstructive apnea is defined as at least a 10-second drop in ventilation (at least 90% drop of peak signal excursion) associated with ongoing ventilatory effort. Obstructive hypopnea is a 30% or greater reduction of air exchange with an associated fall in oxygen saturation of at least 3% or 4%. Respiratory event-related arousals (RERAs) are scored if there is a sequence of breaths lasting at least 10 seconds characterized by increasing respiratory effort or flattening of the nasal pressure waveform leading to an arousal from sleep when the sequence of breaths does not meet criteria for an apnea or hypopnea. The Apnea/Hypopnea Index (AHI) is defined as the total number of apneas and hypopneas per hour of sleep. The Respiratory Disturbance Index (RDI) is defined as the number of apneas, hypopneas, and RERAs per hour of sleep. When sleep onset and offset are unknown (eg, in home sleep studies), the RDI may be calculated based on the number of apneas and hypopneas

per hour of recording time. OSA is considered to be clinically significant when an adult patient has an AHI of 5 or more and symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke. An AHI of 15 to 30 is typically considered moderate OSA, while an AHI of 30 or more is considered severe OSA. Due to faster respiratory rates in children, pediatric scoring criteria define an apnea as 2 or more missed breaths, regardless of its duration in seconds. Hypopneas are scored by a 50% or greater drop in nasal pressure and either a 3% or more decrease in oxygen saturation or an associated arousal. In pediatric patients, an AHI greater than 1.5 is considered abnormal, and an AHI of 15 or more is considered severe.

A condition related to OSA has been termed upper airway resistance syndrome (UARS). UARS is characterized by a partial collapse of the airway resulting in increased resistance to airflow. The increased respiratory effort is associated with multiple sleep fragmentations, as measured by very short alpha electrocardiogram arousals (RERAs). UARS can occur in the absence of snoring and in patients who are not overweight. The resistance to airflow is typically subtle and does not result in apneic or hypopneic events. However, increasingly negative intrathoracic pressure during inspiration can be measured using an esophageal manometer. RERAs can also be detected absent manometry during polysomnography. It has been proposed that UARS is a distinct syndrome from OSA that may be considered a disease of arousal. In the absence of intrathoracic pressure monitoring, a positive response to continuous positive airway pressure (CPAP) has also been used to support the diagnosis.

TREATMENT

Nonsurgical Treatments

Nonsurgical treatment for OSA or UARS includes CPAP or orthodontic repositioning devices, which are addressed in MP #529. Traditional surgeries for OSA or UARS include uvulopalatopharyngoplasty (UPPP) and a variety of maxillofacial surgeries such as mandibular-maxillary advancement (MMA). UPPP involves surgical resection of the mucosa and submucosa of the soft palate, tonsillar fossa, and the lateral aspect of the uvula. The amount of tissue removed is individualized for each patient, as determined by the potential space and width of the tonsillar pillar mucosa between the 2 palatal arches. UPPP enlarges the oropharynx but cannot correct obstructions in the hypopharynx. Thus, patients who fail UPPP may be candidates for additional procedures, depending on the site of obstruction. Additional procedures include hyoid suspensions, maxillary and mandibular osteotomies, or modification of the tongue. Drug-induced sleep endoscopy and/or cephalometric measurements have been used as methods to identify hypopharyngeal obstruction in these patients. The first-line treatment in children is usually adenotonsillectomy. Minimally invasive surgical approaches are being evaluated for OSA in adults.

Laser-Assisted Uvulopalatoplasty

Laser-assisted uvulopalatoplasty (LAUP) is an outpatient procedure proposed as a treatment of snoring with or without associated OSA. In this procedure, superficial palatal tissues are sequentially reshaped using a carbon dioxide laser. The extent of the surgery is typically different from standard UPPP, because only part of the uvula and associated soft-palate tissues are reshaped. The procedure does not remove or alter tonsils or lateral pharyngeal wall tissues. The patient undergoes from 3 to 7 sessions at 3- to 4-week intervals. One purported advantage of LAUP is that the amount of tissue ablated can be titrated so treatment can be discontinued once snoring is eliminated. LAUP cannot be considered an equivalent procedure to the standard UPPP, with the laser simply representing a surgical tool that the physician may opt to use. LAUP is considered a unique procedure, which raises its own issues of safety and, in particular, effectiveness.

Tongue Base Suspension

In this procedure, the base of the tongue is suspended with a suture that is passed through the tongue and fixated with a screw to the inner side of the mandible, below the tooth roots. The aim of the suspension is to make it less likely for the base of the tongue to prolapse during sleep. Radiofrequency Ablation of Palatal Tissues and Base of Tongue Radiofrequency ablation (RFA) of the soft palate is similar in concept to LAUP, although a different energy source is used. Radiofrequency is used to produce thermal lesions within the tissues rather than using a laser to ablate the tissue surface, which may be painful. For this reason, RFA appears to be growing in popularity as an alternative to LAUP. In

some situations, radiofrequency of the soft palate and base of tongue are performed together as a multilevel procedure.

Palatal Stiffening Procedures

Palatal stiffening procedures include insertion of palatal implants, injection of a sclerosing agent (snoreplasty), or a cautery-assisted palatal stiffening operation (CAPSO). The CAPSO procedure uses cautery to induce a midline palatal scar designed to stiffen the soft palate to eliminate excessive snoring. The palatal implant device is a cylindrically shaped segment of braided polyester filaments that is permanently implanted submucosally in the soft palate.

Hypoglossal Nerve Stimulation

Stimulation of the hypoglossal nerve contracts the genioglossus muscle, the largest upper airway dilator muscle. This causes tongue protrusion and stiffening of the anterior pharyngeal wall, potentially decreasing apneic events. Hypoglossal nerve stimulation systems include an implantable neurostimulator, stimulating leads, and electrodes. Stimulation systems such as the Inspire II Upper Airway Stimulation System include respiratory sensing leads that permit intermittent stimulation during inspiration. Stimulation parameters are titrated during an in-laboratory polysomnography and can be adjusted by the patient during home use. The device is turned on only during sleep periods.

Summary

Obstructive sleep apnea (OSA) syndrome is characterized by repetitive episodes of upper airway obstruction due to the collapse of the upper airway during sleep. For patients who have failed conservative therapy, established surgical approaches may be indicated. This evidence review addresses minimally invasive surgical procedures for the treatment of OSA. They include laser-assisted uvuloplasty, tongue base suspension, radiofrequency volumetric reduction of palatal tissues and base of tongue, palatal stiffening procedures, and hypoglossal nerve stimulation. This evidence review does not address conventional surgical procedures such as uvulopalatopharyngoplasty, hyoid suspension, surgical modification of the tongue, maxillofacial surgery, or adenotonsillectomy.

For individuals who have OSA who receive laser-assisted uvulopalatoplasty, tongue base suspension, radiofrequency volumetric reduction of palatal tissues and base of tongue, palatal stiffening procedures, or hypoglossal nerve stimulation, the evidence includes case series, cohort studies, and randomized controlled trials (RCTs). Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The evidence on nearly all of the minimally invasive surgical procedures reviewed herein has shown limited efficacy in patients with mild-to-moderate OSA and has not improved Apnea-Hypopnea Index (AHI) or excessive daytime sleepiness in adults with moderate-to-severe OSA. Hypoglossal nerve stimulation has shown improved outcomes in single arm studies when used in a very select group of patients. In the largest study to date, two-thirds of patients who met inclusion criteria for AHI, body mass index, and favorable pattern of palatal collapse met the study definition of success. However, the role of nerve stimulation among the surgical procedures for OSA treatment is uncertain. RCTs comparing hypoglossal nerve stimulation to conventional surgical procedures are needed to evaluate benefits and harms. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

Date	Action
2/2019	Policy statements on adenotonsillectomy in children with obstructive sleep apnea and hypertrophic tonsils revised. Effective 2/1/2019.
6/2018	Clarified coding information.
1/2018	Clarified coding information.
10/2017	New references added from BCBSA National medical policy.
5/2017	BCBSA National medical policy review. Medically necessary policy statement revised to include variants of palatopharyngoplasty. New references added. Effective 5/1/2017.
1/2017	Clarified coding information for the 2017 code changes.
6/2016	Clarified coding information.

10/2014	BCBSA National medical policy review. New investigational indications described. Coding information clarified. Effective 10/1/2014.
5/2014	Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.
3/2014	Coding information clarified.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
4/2011	Reviewed - Medical Policy Group - Cardiology and Pulmonology. No changes to policy statements.
3/2011	Reviewed - Medical Policy Group - ENT/Otolaryngology. No changes to policy statements.
12/2010	Review of BCBSA policy. Changes made to policy statement.
9/2010	Review of BCBSA policy. Changes made to policy statement.
3/2010	Reviewed - Medical Policy Group - Pulmonology, ENT and Otolaryngology. No changes to policy statements.
8//2009	Medical Policy 130 developed. Effective 8/1/2009.
5/2008	Updated to clarify coverage exclusion of radiofrequency volumetric tissue reduction of the palatal tissues with coblation technology.
2/2008	Review of BCBSA policy. No changes to policy statements.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

References

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Endnotes

¹ Based on expert opinion and the American Academy of Otolaryngology - Head and Neck Surgery [Clinical Practice Guideline: Polysomnography for Sleep-Disordered Breathing Prior to Tonsillectomy in Children](#). Otolaryngol Head Neck Surg. 2011 Jul;145.