The recommendations from the Danish Health Technology Council

Treatment of Patients with Obstructive Sleep Apnea

The recommendations from the Danish Health Technology Council:

Mild OSA[1]
5 ≤ AHI[2] < 15

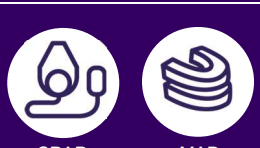
The Danish Health Technology Council recommends no active treatment.


No active treatment

Moderate OSA
15 ≤ AHI < 30

The Danish Health Technology Council recommends Positive Airway Pressure (CPAP) and Mandibular Advancement Devices (MAD).

For patients with position-dependent OSA who cannot tolerate CPAP or MAD, the Danish Health Technology Council recommends positional therapy.


CPAP MADs


Positional therapy

Severe OSA
AHI ≥ 30

The Danish Health Technology Council recommends CPAP and MAD.


CPAP MADs

Surgical Treatment Options:
The Danish Health Technology Council recommends that patients with moderate to severe OSA, who have the appropriate surgical indication, may be treated with soft tissue surgery, including tonsillectomy, tonsil/palate surgery or tongue/epiglottis surgery.

The Danish Health Technology Council recommends that *Maxillomandibular advancement surgery* (MMA) and *Upper Airway Stimulation* (UAS) should only be offered to highly selected patients with moderate to severe OSA who have tried other treatment options without success.

The Danish Health Technology Council recommends that surgical treatment should only be performed after specialist evaluation, where there are clear indications that surgery may be effective according to clinical guidelines.


Surgery

About the Recommendation:
The recommendation is based on the fact that The Danish Health Technology Council see potential for a more cost-effective treatment area for patients with OSA than today. The Danish Health Technology Council acknowledges that the evidence reflects a need to have various

[1] Obstructive sleep apnea (OSA) is a sleep-related respiratory disorder characterised by recurrent pauses in breathing (apneas) or partial pauses (hypopneas) during sleep, caused by complete or partial obstruction of the upper airways.

[2] The apnea-hypopnea index (AHI) indicates the number of apneas and hypopneas per hour of sleep and also reflects the severity of the condition.

equivalent treatment options available in order to choose the right treatment for the right patient based on the right indications. The Danish Health Technology Council assesses that multiple treatments for patients with OSA have positive clinical effects and give patients the opportunity to maintain an active life and possibly remain in the labour market.

The Danish Health Technology Council notes that the organisation of individual patient care pathway is inconsistent across the country. Therefore, the Danish Health Technology Council encourages that the implementation of this recommendation is to be supported by a clinical guideline in order to create equal access to treatment and more uniform patient care pathways for patients with OSA in Denmark. The Danish Health Technology Council assess that standardizing the patient care pathways across the country can lead to less waste of healthcare resources. Therefore, the Danish Health Technology Council encourages that a clinical guideline focus on systematizing the diagnostic and treatment pathways for patients with OSA and include a strategy for selecting treatment for the individual patient to create an effective first-line treatment.

The Danish Health Technology Council points out that due to the existing registration practices, there is significant uncertainty associated with data regarding the number of patients with OSA in Denmark. The result of the budget impact analysis should be seen in this light and should also be viewed in conjunction with the performed health economic analyses.

Mild OSA
The recommendation for patients with mild OSA is based on the fact that the clinical evidence does not support the clinical effectiveness of treatment with either CPAP or MAD.

Moderate and Severe OSA
The recommendation for patients with moderate and severe OSA is based on clinical evidence showing that CPAP, MAD, and positional therapy lead to positive clinical effects in the form of reduced perceived daytime sleepiness and reduced severity of OSA. The effectiveness of positional therapy has primarily been investigated in patients with moderate OSA, which is why this therapy is only recommended for patients with moderate OSA. The evidence underscores that CPAP and MAD are the most clinically effective non-invasive treatment options for patients with moderate to severe OSA. Additionally, the Danish Health Technology Council assesses that treatment with CPAP and MAD are the most cost-effective non-invasive treatments for patients with moderate to severe OSA. The Danish Health Technology Council also assess that positional therapy can be a cost-effective treatment for patients with positional OSA.

Surgical Treatment Options
The Danish Health Technology Council assess that the health economic analyses reflect the advantages of a curative treatment with surgical procedures. However, surgical procedures are also associated with greater risks for patients, why the choice of the right treatment should depend on individual patient conditions, including anatomy, age, and lifestyle. In general, soft tissue surgery (including tonsil/palate surgery, tongue/epiglottis surgery, and multi-level surgery) shows good clinical effectiveness and cost-effectiveness. Due to the evidence base, significant cost levels, and the extensive and risky patient pathway, MMA and UAS should only be offered to highly selected patients who have the right indication and have tried other treatment options without success.

About the Treatments	The recommendations pertain to several treatment options for patients with OSA. These treatment options include: CPAP: Treatment with CPAP involves the patient receiving continuous positive airway pressure from a device connected to a hose and a mask that covers the nose and/or mouth during sleep. The purpose of CPAP is to stabilise the pharynx using positive pressure, thereby maintaining free respiration. MAD: MAD, also referred to as mandibular advancement devices or sleep splints, are attached to the upper and lower dental arches to secure the lower jaw in a forward position relative to the upper jaw. The advancement of the lower jaw increases the space in the upper airways, primarily at the base of the tongue and the epiglottis, thereby reducing collapses and obstructions. Currently, treatment with MAD is offered only to a very limited extent in the public healthcare system. The basis for this analysis assumes that MAD treatment will be offered as a public healthcare service in the future. Positional Therapy: The purpose of positional therapy is to encourage the patient to sleep on their side rather than in a supine position. In positional therapy, the patient may use a vibration belt that activates when they lie on their back or wear a shirt with a sewn-in ball positioned on the back. Surgical treatment of OSA can be broadly categorised into three types: Soft Tissue Surgery: Soft tissue surgical procedures involve the removal or reduction of tissue in the oropharynx and pharynx to increase space and reduce collapses in the upper airways. These procedures may include the removal of tonsils, parts of the soft palate and uvula, and reductions of the palatal arches, tongue base, and epiglottis. UAS: UAS involves the implantation of a nerve stimulator on the nerve controlling the tongue muscle and a sensor electrode that detects when the chest muscles activate during the initiation of inhalation. Electrical stimulation advances the tongue during inhalation, preventing upper airway collapse. MMA: In MMA, both the upper jaw and the tooth-bearing portion of the lower jaw are loosened and advanced to create additional space in the pharyngeal airway behind the tongue. No Active Treatment: Patients who do not receive active treatment are not provided with any direct interventions from the healthcare system but may receive guidance on lifestyle modifications and sleep hygiene.
Patient Population	The recommendation pertains to adult patients (>18 years) with obstructive sleep apnea of mild (5 ≤ AHI < 15), moderate (15 ≤ AHI < 30), or severe (AHI ≥ 30) severity.
Scope of Application	The recommendation applies to the treatment of OSA within the healthcare system. It may have implications for clinical practice across several medical specialties, including otorhinolaryngology, maxillofacial surgery, pulmonology, neurology, and anaesthesiology.
Implementation	The Council notes that the implementation of the recommendation requires an increased focus on offering the appropriate treatment to the right patient based on the correct indication. Different treatment options are anchored in various medical

	specialties, and the Council emphasises that implementing the recommendation necessitates enhanced interdisciplinary collaboration between different medical specialties and departments involved in individual patient care. The Council also observes that selecting the appropriate treatment may require attention to the underlying cause of the disease during referral and diagnosis. Furthermore, it may be relevant to standardise referral, diagnostic, and treatment processes for patients, with an emphasis on ensuring equal access to care across the country. In this context, the Council highlights that implementing the recommendation presupposes a strategy for treatment selection to avoid waste of healthcare resources. The Council therefore recommends that the implementation of this recommendation be supported by a clinical guideline containing criteria for treatment selection. The Council also notes that there will be a need to organise a treatment pathway for MAD. In this regard, there may be a need for initial and ongoing skill development for the responsible healthcare personnel to ensure they possess the relevant competencies for employing new treatment options.
Procurement	It is proposed that a renewed national procurement process for CPAP and positional therapy be conducted upon the expiration of the existing joint regional agreement. Additionally, a national procurement process for MAD equipment is proposed if the treatment is offered in hospitals.

Summary from the Analysis Report

About the Analysis

The Danish Health Technology Council's recommendations are based on an analysis report concerning the treatment of patients with obstructive sleep apnea. The purpose of the analysis is to address the following question:

What treatments should be offered to patients with obstructive sleep apnea?

The analysis includes an assessment of the following treatment options for patients with mild, moderate, and severe OSA:

1. CPAP (CPAP, APAP, biPAP)
2. MAD (custom-fitted, bi-block)
3. Positional Therapy
4. Surgery (tonsil/palate surgery, tongue/epiglottis surgery, multi-level surgery, UAS, and MMA)
5. No Active Treatment (e.g., no treatment, placebo, sham treatment, or lifestyle counselling)

Clinical Effectiveness and Safety

The analysis of Clinical effectiveness and safety is based on a total of 99 randomized controlled trials (RCTs) covering the various treatment options and subgroups. The evidence for CPAP includes comparative data on all outcome measures. For the remaining treatment options, the evidence primarily addresses the intermediate outcomes of 'Severity', 'Blood Pressure', and 'Daytime Sleepiness'. The Expert Committee places particular emphasis on the evaluation of the outcomes 'Severity' and 'Daytime Sleepiness', as these outcomes are highly influential in guiding the clinical management of patients with OSA and significantly impact their overall quality of life.

Regarding the analysis' primary subgroups of patients with mild, moderate, and severe OSA, the Expert Committee has evaluated whether the results for Clinical effectiveness and safety support the efficacy of the various interventions included in this analysis:

Subgroup	Effective Treatment Options	Comments
Patients with mild OSA		MAD and CPAP show effectiveness only for 'Severity' and not for other important patient-relevant outcomes such as 'Daytime Sleepiness'. However, patients with mild OSA and severe daytime sleepiness may experience a good effect from treatment. MAD and CPAP show comparable treatment effect in this subgroup compared to no active treatment.
Patients with moderate OSA	CPAP MAD	All treatment options have clinically relevant effects on the important outcomes ' Severity' and 'Daytime Sleepiness'.

	Positional Therapy Surgery	CPAP shows a larger treatment effect than MAD and positional therapy on 'Severity'. MAD demonstrates clinically improved adherence compared to CPAP. Positional therapy has primarily been studied in patients with moderate OSA. Surgery is an effective treatment for patients with anatomical indications for specific interventions. The different treatment options cannot be ranked based on the analysis of Clinical effectiveness and safety.
Patients with severe OSA	CPAP MAD Surgery	CPAP, MAD, and Surgery show clinically relevant effects on the important outcomes 'Severity' and 'Daytime Sleepiness'. CPAP shows a larger treatment effect than MAD on 'Severity'. Surgery is an effective treatment for patients with anatomical indications for specific interventions. The different treatment options cannot be ranked based on the analysis of Clinical effectiveness and safety.

The included RCT studies did not demonstrate the effectiveness of CPAP treatment on long-term complications such as 'Cardio-/Cerebrovascular Events' and 'Mortality'. The Expert Committee notes that the RCT studies have relatively short follow-up periods compared to the time frame for the development of such long-term complications. Additionally, the analysis generally does not show clinically relevant effects of non-invasive treatment on 'Blood Pressure'.

The Expert Committee assesses that the evidence generally does not support the effectiveness of treating patients with mild OSA. However, they emphasise that the severity of OSA is not correlated with patients' daily symptoms. Therefore, individual considerations may indicate that patients with mild OSA and severe symptoms could benefit from treatment with CPAP or MAD.

The Expert Committee concludes that the evidence supports the effectiveness of treating patients with moderate and severe OSA using CPAP, MAD, and surgery. However, the Expert Committee highlights that the effectiveness of each treatment option depends on the patient's anatomy and the etiological cause of their OSA. CPAP is the treatment option with the broadest applicability among OSA patients, as its effectiveness is less dependent on patient anatomy compared to other treatment options. The effectiveness of MAD and surgery, however, is significantly influenced by the patient's anatomy. Therefore, the Expert Committee emphasises that the patient's anatomical features should be considered when determining the most appropriate treatment. Surgical interventions may carry substantial risks of complications, and the Expert Committee advises that UAS and MMA should only be offered to highly selected patient groups who have tried

alternative treatments. Soft tissue surgery is a less extensive procedure that has shown good efficacy in selected patients with moderate to severe OSA.

Patients with POSA should not be treated differently from patients with general OSA. However, these patients have an additional treatment option in the form of positional therapy, which demonstrates significant clinical effectiveness on the outcome measure of ‘Severity’. However, this effectiveness is supported by evidence only for patients with moderate OSA.

In general, the Expert Committee emphasises that the selection of the most appropriate treatment should always be based on the individual patient, their anatomy, the clinical presentation of OSA, and general factors such as age and lifestyle. The Expert Committee further notes that the clinical management of OSA is not limited to the treatment options included in this analysis. The management of OSA, along with frequently associated comorbidities, is complex. The Expert Committee therefore underscores the importance of additional measures, such as counselling on lifestyle factors (e.g., diet, exercise, smoking cessation, and alcohol moderation), sleep hygiene, and, in some cases, weight loss interventions. They also highlight that the treatment of sleep apnea may have beneficial effects on other comorbidities by improving the patient’s overall health.

The assessment of evidence quality using the *Grading of Recommendations, Assessment, Development, and Evaluation* (GRADE) framework varies across the respective outcomes and analysed subgroups. The evaluation of evidence quality for CPAP and MAD compared with no active treatment in patients with mild OSA indicates moderate and very low confidence in the results for the outcomes 'Severity' and ‘Daytime Sleepiness’, respectively. For CPAP and MAD compared with no active treatment in patients with moderate to severe OSA, the evidence quality assessment indicates very low confidence in the results for both ‘Severity’ and ’Daytime Sleepiness’. For surgical interventions, there is generally moderate confidence in the results for the outcomes ‘Severity’ and ‘Daytime Sleepiness’. The assessment of evidence quality for CPAP, MAD, and positional therapy compared with no active treatment in patients with positional POSA indicates low confidence in the results for both ‘Severity’ and ‘Daytime Sleepiness’.

Patient Perspective

The analysis of the patient perspective is based on 25 qualitative interview studies identified through a systematic literature review, focusing on patient or partner experiences with one or more treatment options for OSA. For treatment options where no relevant literature addressing the research question was identified, expert opinions were utilised.

The analysis of *patient* literature (referenced in Section 7.2) highlights several facilitating factors and barriers regarding the use of treatment options such as CPAP, MAD, positional therapy, and UAS, as well as the decision to undergo surgical interventions (soft tissue surgery, MMA, or UAS implantation). The evidence does *not* provide an indication of how many patients experience these facilitating factors and barriers.

The facilitating physical factors are associated with the bodily benefits of the treatments, such as improved sleep, increased energy (CPAP, MAD, positional therapy, and UAS), and, for certain surgical interventions, the prospect of potential OSA resolution (soft tissue surgery and MMA). The discreet nature of some treatments can also serve as a facilitating physical factor (MAD, positional therapy, and UAS). Physical barriers include issues such as mask fitting problems (CPAP) and altered bite alignment or pain during the adjustment phase (MAD). Other physical barriers may involve disrupted sleep (positional therapy and UAS), the

expectation of severe postoperative pain and difficulty swallowing (soft tissue surgery), as well as the risk of nerve pain and the prospect of an extensive treatment process (MMA).

The facilitating relational factors pertain to the surrounding environment, including the desire of close relations for treatment initiation, the partner benefiting from improved sleep (CPAP), and the importance of support and assistance from partners and healthcare professionals (UAS). Discreet treatment options (MAD and positional therapy) can also serve as facilitating factors on a relational level, as they are easier to conceal from others. The relational barriers involve a changed self-image, including a reduced sense of physical attractiveness (CPAP).

The facilitating psychological factors include the greater mental well-being that can result from improved sleep (CPAP), the sense of minimal stigmatisation (positional therapy), and the psychosocial benefits of bite normalisation, which may enhance appearance (MMA). The psychological barriers are related to experiences of stigmatisation from others, leading to a negative self-image (CPAP). In some cases, the treatment may provoke claustrophobia (CPAP) and anxiety (CPAP, UAS).

The facilitating organisational factors include early follow-up after treatment initiation (CPAP), involvement in the selection of equipment (CPAP), and comprehensive patient education about both OSA and the specific treatment (CPAP, surgery). The organisational barriers are centred around the burden of equipment maintenance (CPAP, MAD).

The analysis of *partner* literature (referenced in Section 7.3) reveals that partners play a central role in establishing new routines around treatment and its daily management during the initial phase (CPAP). The initiation and use of treatment options may have psychological, physical, and relational implications for partners. The psychological implications include both positive factors, such as hope for a longer and improved life together, and negative factors, such as anxiety regarding mask usage and feelings of guilt when the treatment is primarily used for the partner's benefit (CPAP). The physical implications are significant, focusing on improved sleep due to reduced snoring and fewer apneas in the patient (all treatment options). The relational implications involve the desire to share a bedroom again (CPAP and MAD), thereby improving opportunities for intimacy and communication. However, challenges may arise, such as difficulties with close physical contact and casual conversation (CPAP).

There is concern regarding the validity of several of the included interview studies, as the recruitment strategies and data collection methods are not sufficiently described. Additionally, the relationship between researchers and participants is often not communicated. Confidence in the main findings of the thematic synthesis is predominantly high but has been consistently downgraded for relevance due to uncertainty about whether the study populations reflect the target population as specified in the PICO framework.

Overall, the Expert Committee considers that the identified findings under the Patient Perspective align with their everyday experiences with the patient group. Additionally, the Expert Committee notes that there is particularly strong support for CPAP among patients who experience positive effects from the treatment and who receive professional help in managing initial challenges with the equipment. However, the Expert Committee's experience is that patients request alternative treatment options to CPAP in cases where challenges with the treatment arise. These alternatives may include MAD, positional therapy, or surgery – if the appropriate indications are met. The Expert Committee therefore believes that more

	patients would use MAD as a treatment for OSA if it were not self-funded. Similarly, positional therapy or surgery would be chosen if patients had the option. Furthermore, the Expert Committee notes that patient involvement in the treatment decision-making process is crucial, and this may result in patients choosing alternatives to CPAP. As such, more patients would likely achieve satisfactory and adequate treatment for OSA.
Organisational Implications	The analysis of the Organisational Implications is based on written clinical treatment guidelines, care pathway descriptions, and patient materials. This is supported by semi-structured interviews with selected clinical experts within each of the individual treatment options. Additionally, the entire Expert Committee and its members have each contributed their knowledge and experience regarding the individual treatment options and their organisation. The analysis of the submitted clinical treatment guidelines and pathway descriptions reveals significant inter- and intraregional variation in how treatment pathways for the individual treatment options for patients with OSA are organised across regions. Expert interviews and the Expert Committee report that the inter- and intraregional variation in the organisation of OSA treatment reflects differences in the healthcare specialties to which the treatment options are locally affiliated, and therefore, which treatment options are offered to each patient. The expert interviews and the Expert Committee highlight that there are both advantages and disadvantages to the various organisational structures and the affiliation of OSA treatment with specific healthcare specialties. If a broader range of treatment options is to be made available to patients with OSA, there is a need to establish systematic, interdisciplinary collaboration structures within each treatment option, both interregional and intraregional. This is to ensure that all patients have equal access to treatment, regardless of their residential region. Additionally, the Expert Committee emphasises that uniform and systematic follow-up and monitoring protocols should be ensured for initiated treatments, regardless of the patient's place of residence, to guarantee that patients achieve the desired outcomes from their treatments. The Expert Committee also highlights the potential benefits of utilising digital telemonitoring for treatment modalities where this is feasible. The Expert Committee concludes that there is a need to systematise the overall diagnostic and treatment pathway for patients with OSA to ensure the right treatment is provided to the right patient based on appropriate indications. Additionally, the Expert Committee emphasises the importance of establishing interdisciplinary collaboration across medical specialties and, where necessary, between regions to ensure the inclusion of the appropriate expertise for each treatment option. The Expert Committee underscores that various organisational models may be considered, but patients with OSA should have equal access to treatment options regardless of their region of residence.
Health Economics	To address the health economic perspective, cost-utility analyses (CUA) have been conducted to examine the cost-effectiveness of various treatment options for patients with OSA. Based on the CUA results, the Expert Committee has provided an overall assessment for each of the defined subgroups. The relative cost-effectiveness of the treatment options depends on the willingness-to-pay threshold. Below, the treatments with the highest likelihood of being the most cost-effective for a given hypothetical willingness-to-pay per QALY are outlined. The Expert Committee’s evaluation of the BIA is presented collectively for the subgroups.

For patients with mild OSA, the health economic base-case analysis indicates that CPAP is most likely to be the cost-effective treatment at a willingness-to-pay threshold exceeding approximately 205,000 DKK/QALY. Given the uncertainty associated with the included costs and effects, the Expert Committee assesses that MAD may, in some cases, represent a more cost-effective treatment compared to CPAP. Conversely, for patients with mild OSA, MAD may, in certain instances, be associated with lower effectiveness compared to no active treatment.

For patients with moderate to severe OSA, the base-case analysis indicates that CPAP is most likely to be the most cost-effective treatment at a willingness-to-pay threshold exceeding approximately 125,100 DKK/QALY. Based on the uncertainty associated with the included costs and effects, the Expert Committee assesses that MAD may represent a more cost-effective treatment compared to CPAP.
Similarly, for patients with POSA, the base-case analysis indicates that CPAP is most likely to be the most cost-effective treatment at a willingness-to-pay threshold exceeding approximately 102,800 DKK/QALY. Taking into account the uncertainty associated with the included costs and effects, the Expert Committee considers that positional therapy and MAD may be cost-effective treatment alternatives compared to CPAP.

For the non-invasive treatment options (no active treatment, CPAP, MAD, and positional therapy), a series of sensitivity analyses have been conducted, indicating that the CUAs are subject to uncertainty both in relation to individual parameters and methodological choices in the analyses. Particularly notable is the uncertainty in individual parameters related to the effects of CPAP, MAD, and positional therapy on health-related quality of life, as well as the costs associated with treatment equipment. These factors can all influence the relative cost-effectiveness of the treatment options. Regarding methodological choices in the analyses, the inclusion of patient-incurred costs for cleaning and maintenance has the potential to alter the results of the base-case analysis. However, this is applicable solely to patients with POSA.

For patients with a surgical indication, the base-case analyses show that all surgical treatments are associated with greater effectiveness in terms of accumulated QALYs and higher accumulated costs compared to no active treatment. The Expert Committee notes that tonsil-/palate surgery, in particular, results in a relatively low ICER (35,161 DKK/QALY) compared to multi-level surgery, UAS, and MMA (with ICERs of 138,909 DKK/QALY, 553,178 DKK/QALY, and 157,715 DKK/QALY, respectively). Based on the sensitivity analyses performed for patients with a surgical indication, the Expert Committee assesses that the results are relatively robust.

Particularly for multi-level surgery, UAS, and MMA, the CUA is based on a limited evidence (see section 6.3.4). Due to a lack of evidence, surgical success rates and adverse events (e.g., reoperations) have not been incorporated into the models for surgical procedures. These factors could significantly impact patients' health-related quality of life. The Expert Committee assesses that incorporating these elements would likely result in a higher ICER due to fewer accumulated QALYs and increased accumulated costs. Notably, the Expert Committee emphasises that surgical interventions such as MMA may involve significant risks of severe postoperative complications. Given that MMA and UAS are also associated with relatively high costs, the Expert Committee recommends that UAS and MMA should only be offered to highly selected patients who have already explored other alternatives.

Conversely, the Expert Committee emphasises that for some patients, surgical interventions can lead to a cure. Since several surgical procedures (particularly tonsil-/palate surgery and multi-level surgery) are not associated with costs in the years following the operation, these patients can be discharged from hospital care. This eliminates the need for lifelong treatment and monitoring, reducing the patients' long-term utilisation of healthcare resources. Despite the uncertain evidence, the Expert Committee assesses that surgical treatment can be cost-effective for managing patients with OSA. However, the Expert Committee also highlights that not all patients are candidates for all the surgical treatments examined.

The budget impact analysis estimates that a positive recommendation for all included treatment options will result in a five-year budget impact of approximately 232 million DKK. The Expert Committee emphasises that this budget impact is primarily driven by the large patient population with OSA, estimated to reach 194,000 patients by 2029. The Expert Committee highlights that the data underlying the analysis is subject to significant uncertainty regarding the size of the patient population and the distribution of the population among the included treatment options.

About the Recommendation form the Danish Health Technology Council

The Danish Health Technology Council's recommendation is intended for the regional authorities to support their decision-making regarding the use of a specific health technology or the organisation of a treatment area. The analysis report provides an overview of the following perspectives: 1) Clinical effectiveness and safety, 2) Patient perspective, 3) Organisational implications, and 4) Health economics.

This recommendation is based on the Danish Health Technology Council's analysis report regarding the treatment of patients with obstructive sleep apnea, collaboratively prepared by the Expert Committee and the secretariat. The analysis report was developed in accordance with the analysis design, as well as the Danish Health Technology Council's process guide and methodological guidelines. The Expert Committee's terms of reference, along with other relevant documents, are available on the Danish Health Technology Council's website.

Document Information

Approval Date:	Document Number:	Version Number:
May 24, 2024	----	1.0

Version no.:	Date:	Amendment(s):
1.0	May 24, 2024	Approved by the Danish Health Technology Council