**NO. 91333**

# SLEEP APNEA: OBSTRUCTIVE & CENTRAL

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**Policy scope**: This medical policy addresses the following:

- Testing/diagnostics for obstructive and central sleep apnea
- Treatment of obstructive and central sleep apnea
- Uvulopalatopharyngoplasty (UPPP)
- Laser-assisted uvulopalatoplasty (LAUP)
- Policy applies to adults aged 18 years and older only.

**Related policies**:

- Durable Medical Equipment No. 91110

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## I. MEDICAL NECESSITY CRITERIA

### A. Testing/Diagnostics

1. The following services are considered medically necessary when the applicable InterQual® criteria are met:

a. Facility-Based Polysomnogram (PSG) (Prior Authorization required for members ≥ 18 years)
b. Facility-Based Titration Study (Prior Authorization required for members ≥ 18 years)
c. Multiple Sleep Latency Test (MSLT) or Maintenance of Wakefulness Test (Prior Authorization required for members ≥ 18 years)

2. With the exception of home-based studies, studies must be done by a certified sleep lab facility and be read by a certified sleep specialist.

3. There are no limitations on referrals to in-network sleep specialists.

**B. Treatment of obstructive sleep apnea**

1. The following treatment modalities are covered for OSA when InterQual® are met:
    a. Auto-titrating positive airway pressure (APAP), or
    b. Continuous Positive Airway Pressure (CPAP) if medically indicated.
        i. Bilevel Positive Airway Pressure (BPAP), Demand Positive Airway Pressure (DPAP), and Variable Positive Airway Pressure (VPAP) are covered as DME.
        ii. Humidifiers and heaters for positive airway pressure devices are covered.
        iii. A nasal/face mask or an oral pressure appliance (Oral Positive Airway Pressure - OPAP) are covered as durable medical equipment.
    c. Oral Appliance. Covered under Prosthetics and Orthotics benefit level, applicable copays apply.

2. *Uvulopalatopharyngoplasty (UPPP), uvulectomy, or any other procedures to correct obstructive sleep apnea, are covered benefits if both of the following apply:
    a. Obstructive Sleep Apnea (OSA)
    b. Respiratory Event Index (REI) or Apnea/Hypopnea Index (AHI) is 15 or greater on polysomnography, or two or more of the following are met:
        i. AHI>5 and <15
        ii. >20 episodes of oxygen desaturation < 85% or any one episode of oxygen desaturation < 70%
        iii. Type II second degree heart block or pause > 3 seconds or ventricular tachycardia at a rate > 140/minute lasting > 15 complexes

iv. Excessive daytime sleepiness documented by either Epworth Sleepiness Scale > 10 or Multiple Sleep Latency Test (MSLT) < 8

*A three (3) month trial of CPAP must be completed prior to UPPP. UPPP is a surgical procedure in which the oropharynx is enlarged by excision of the uvula and tissue of the soft palate. A tonsillectomy may also be done with the UPPP; payment for the tonsillectomy will be considered incidental to the more comprehensive UPPP procedure. UPPP, when medically necessary, is a covered benefit.

C. **Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea** (e.g., Inspire Upper Airway Hypoglossal Nerve Stimulator).

FDA-approved hypoglossal nerve neurostimulation (e.g., Inspire Upper Airway Hypoglossal Nerve Stimulator; Inspire Medical Systems, Inc.) is considered medically necessary for the treatment of moderate to severe obstructive sleep apnea (OSA) when the applicable InterQual® criteria are met:

**CP:Procedures**
***Hypoglossal Nerve Stimulation (HNS)***

**D. The following are NOT covered benefits (this list is not all-inclusive):**

1. **Laser - Assisted Uvulopalatoplasty (LAUP).** LAUP has not been proven to be an appropriate or effective treatment of OSA or UARS. (The treatment of snoring by LAUP is not a covered benefit.)

2. **Radiofrequency Ablation** of the tongue base, uvula or soft palate (Somnoplasty) or of the nasal passages and soft palate (Coblation) is considered experimental and investigational as a treatment for obstructive sleep apnea because there is inadequate scientific evidence to validate the effectiveness of these procedures for this indication.

3. **Pillar Procedure.** There is a lack of evidence of short-term or long-term effectiveness of palatal restoration, or Pillar Procedure when performed for either obstructive sleep apnea or snoring.

4. **Tongue-base suspension (i.e., Repose).** The suspension of the anterior tongue by fixation of the soft tissue to the mandible using a bone screw is considered to be experimental and investigational.

5. **Partial Glossectomy** surgical removal of a portion of the tongue or oral cavity in an effort to widen the hypopharynx is considered to be experimental and investigational.

6. **Maintenance of Wakefulness Test (MWT)** objectively measures the ability of an individual to remain awake for a defined period of time. Although the MWT has been used to evaluate the risk for driving, work, or home-related accidents, its validity for this purpose has not been proven and is not a covered benefit.

7. **eXciteOSA device** (Signifier Medical Technologies LLC) for treatment of snoring in patients with primary snoring or mild obstructive sleep apnea. This device is unproven and not medically necessary due to insufficient evidence of efficacy.

8. **Phrenic nerve stimulation (also known as diaphragm pacing) (remede System; Zoll Medical Corporation) for central sleep apnea is considered experimental, investigational, or unproven.** Remede was the topic of the Priority Health Medical Technology Assessment Committee (MTAC) meeting held on November 29, 2023. No evidence-based clinical practice guidelines regarding the use of implantable transvenous phrenic nerve stimulation to treat central sleep apnea are available. In a statement on research priorities for patients with heart failure and central sleep apnea, the American Thoracic Society noted that questions remain regarding the long-term outcomes and comparative effectiveness of treatment with phrenic nerve stimulation (Orr et al., 2021). Available published data suggest that this technology may hold promise, but further research is needed.

9. Premarket approval for the remedē System (Respicardia Inc.), a class III device, was issued by the FDA on October 6, 2017 (P160039) (product code PSR, implanted phrenic nerve stimulation [PNS] devices for central sleep apnea [CSA]). Zoll Medical Corporation acquired Respicardia Inc. in April 2021. Currently, this is the only implanted nerve stimulation device approved for the treatment of CSA.

## II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare

Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

| National Coverage Determinations (NCDs) | |
|---|---|
| Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA) 240.4<br><br>Sleep Testing for Obstructive Sleep Apnea (OSA) 240.4.1<br><br>Durable Medical Equipment Reference List 280.1 | |
| **Local Coverage Determinations (LCDs)** | |
| CGS Administrators, LLC | Oral Appliances for Obstructive Sleep Apnea L33611 A52512<br><br>Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea L33718 A52467<br><br>Polysomnography and Other Sleep Studies L36902 A57049<br><br>Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea L38307 A57149 |
| First Coast Service Options, Inc. | Polysomnography and Sleep Testing L33405 A57496<br><br>Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea L38398 A56953 |
| Wellpoint Federal (formerly National Government Services, Inc.) | Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea L38387 A57092 |
| Noridian Healthcare Solutions | Oral Appliances for Obstructive Sleep Apnea L33611 A52512<br><br>Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea L33718 A52467<br><br>Polysomnography and Other Sleep Studies L36861 A57697<br><br>Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea L38310 A57948 |

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|---|---|
| Novitas Solutions, Inc. | Outpatient Sleep Studies L35050 A56923<br><br>Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea L38385 A56938 |
| Palmetto GBA | Polysomnography L36593 A56995<br><br>Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea L38276 A58075 |
| WPS Insurance Corporation | Surgical Treatment of Obstructive Sleep Apnea (OSA) L34526 A56905<br><br>Polysomnography and Other Sleep Studies L36839 A56903<br><br>Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea L38528 A57944 |

## III. BACKGROUND

Obstructive Sleep Apnea (OSA) is characterized by the collapse and obstruction of the upper airway during sleep, leading to sleep fragmentation. In this syndrome, respiratory efforts persist but are ineffective due to obstruction that may occur anywhere in the upper airway. The most common complaints associated with OSA are snoring and excessive daytime sleepiness. Snoring, although it may be a social problem, is not a medical condition.

The Apnea/Hypopnea Index (AHI) is determined by attended polysomnography, equal to the total number or apneas and hypopneas x 60 divided by the total sleep time in minutes. Apnea is scored if airflow is reduced by >90% for at least 10 seconds. Hypopneas are scored if there is a drop by >30% of pre-event baseline airflow lasting at least 10 seconds, resulting in an EEG arousal or >3% oxyhemoglobin desaturation.

The Respiratory Event Index (REI) is equal to the average number of episodes of apnea and hypopnea events per hour of recording and must be based on a minimum of 2 hours of time recorded by unattended polysomnography. Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in airflow as compared to baseline, resulting in at least a 3% oxyhemoglobin desaturation.

If the AHI or REI is calculated based on less than 2 hours of sleep or recording time, the total number of recorded events used to calculated the AHI or RDI (respectively) must be at least the number of events that would have been required in a 2 hour period (i.e., must reach >30 events without symptoms or >10 events with symptoms).

Standard Classifications of OSAS according to Apnea/Hypopnea Index (AHI)15

| | |
|---|---|
| Mild: | greater than 5 and less than 15 |
| Moderate: | 15 to 30 |
| Severe: | greater than 30 |

The diagnosis of sleep apnea may require confirmation by sleep laboratory studies. Patients' symptoms and the frequency of respiratory events on laboratory testing are important factors in determining the severity of disease. In patients with mild sleep apnea, conservative treatment measures include getting sufficient sleep, abstaining from the use of alcohol, tobacco, and sedatives, losing weight, and avoiding the supine position during sleep. Many patients with documented sleep apnea require more than conservative therapy. Continuous positive airway pressure (CPAP) is the most consistently effective treatment for clinically significant obstructive sleep apnea.

Palatal surgical procedures tend to alleviate snoring but are not consistently effective in treating sleep apnea. Many patients with sleep apnea have airway obstruction beyond the palatal area that is not treated by soft tissue procedures.

**Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea**

Diminished muscle activity or tone in the upper airway during sleep can cause the tongue to slip from its normal position and occlude the pharynx, thereby obstructing the airway, creating the conditions for obstructive sleep apnea (OSA). Mild electrical stimulation to the medial branch of the hypoglossal nerve (HGN) can produce selective motor stimulation of the horizontal-longitudinal muscle fibers that draw the tongue forward via activation of the genioglossus muscle. This results in improvement of upper airway obstruction, ideally without arousal or patient discomfort.

An HGN stimulation (HGNS) system consists of 3 implanted components: a small implanted pulse generator (IPG), a respiratory-sensing lead, and a stimulating lead surgically placed on the HGN. The IPG is subcutaneously implanted beneath the clavicle in the upper chest and delivers HGNS via the stimulating lead. The sensing lead is placed in the intercostal space and contains a piezoelectric differential pressure sensor for detecting respiratory signals. The IPG synchronizes stimulation of the hypoglossal nerve with the patient's breathing cycle using input from the sensing lead. The device may be activated 4 to 6 weeks after surgical implantation and the stimulation is titrated to yield ideal outcomes coupled with minimal side effects for each patient. Titrations can occur several times over the months following implantation. The patient uses a remote control to turn the device on before going to sleep and turn it off upon awakening.

InterQual® Procedures criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included:

- PubMed
- Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews
- the Cochrane Library
- Choosing Wisely
- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations
- the National Institute of Health and Care Excellence (NICE), and
- the National Guideline Clearinghouse.

Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have been used. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose-response gradient and the likely effect of plausible confounders.

## IV. GUIDELINES / POSITION STATEMENTS

| Medical/Professional Society | Guideline |
|---|---|
| American Academy of Otolaryngology-Head and Neck Surgery | Position Statement: Treatment of Obstructive Sleep Apnea (June 9, 2021).<br><br>Position Statement: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (OSA) (November 13, 2019) |
| American Academy of Sleep Medicine | Clinical Practice Guideline for Diagnostic Testing for Adult Obstructive Sleep Apnea: An American Academy of Sleep Medicine Clinical Practice Guideline (March 15, 2017).<br><br>Treatment of Adult Obstructive Sleep Apnea with Positive Airway Pressure: An American Academy of Sleep Medicine Clinical Practice Guideline (February 15, 2019)<br><br>Clinical Guidelines for the Manual Titration of Positive Airway Pressure in Patients with Obstructive Sleep Apnea (April 15, 2008)<br><br>Clinical Practice Guideline for the Treatment of Obstructive Sleep Apnea and Snoring with Oral Appliance |

| | |
|---|---|
| | Therapy: An Update for 2015 (July 15, 2015)<br><br>Practice Parameters for the Medical Therapy of Obstructive Sleep Apnea (2006)<br><br>Updated Adaptive Servo-Ventilation Recommendations for the 2012 AASM Guideline: "The Treatment of Central Sleep Apnea Syndromes in Adults: Practice Parameters with an Evidence-Based Literature Review and Meta-Analyses" (May 15, 2016)<br><br>Referral of adults with obstructive sleep apnea for surgical consultation: an American Academy of Sleep Medicine clinical practice guideline (December 1, 2021)<br><br>Treatment of central sleep apnea in adults: an American Academy of Sleep Medicine clinical practice guideline (August 18, 2025)<br><br>Clinical use of a home sleep apnea test: An updated American Academy of Sleep Medicine position statement (December 15, 2018)<br><br>Practice Parameters for the Respiratory Indications for Polysomnography in Children (2011)<br><br>Practice Parameters for the Non-Respiratory Indications for Polysomnography<br>and Multiple Sleep Latency Testing for Children (2012)<br><br>American Academy of Sleep Medicine Position Paper for the Use of a Home Sleep Apnea Test for the Diagnosis of OSA in Children (October 15, 2017)<br><br>Recommended protocols for the Multiple Sleep Latency Test and Maintenance of Wakefulness Test in children: guidance from the American Academy of Sleep Medicine (April 1, 2024) |

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|---|---|
| American Society of Anesthesiologists (ASA) | Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea<br>An Updated Report by the American Society of Anesthesiologists Task Force on Perioperative Management of Patients with Obstructive Sleep Apnea (February 2014) |
| American Thoracic Society | The Role of Weight Management in the Treatment of Adult Obstructive Sleep Apnea. An Official American Thoracic Society Clinical Practice Guideline (October 2018)<br><br>An Official American Thoracic Society Clinical Practice Guideline: Sleep Apnea, Sleepiness, and Driving Risk in Noncommercial Drivers. An Update of a 1994 Statement (December 2012) |
| National Institute for Health and Care Excellence (NICE) | Home-testing devices for diagnosing obstructive sleep apnoea hypopnoea syndrome (December 19, 2024)<br><br>Phrenic nerve pacing for congenital central hypoventilation syndrome (August 21, 2024)<br><br>Daytime intraoral neuromuscular electrical tongue stimulation using a removable device for obstructive sleep apnoea (April 19, 2023)<br><br>Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome (August 20, 2021)<br><br>Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s (August 20, 2021)<br><br>Hypoglossal nerve stimulation for moderate to severe obstructive sleep apnoea (November 22, 2017)<br><br>Soft-palate implants for obstructive sleep apnoea (November 28, 2007) |

## V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

| Device | Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number | Decision Date |
|---|---|---|
| Inspire® Upper Airway Stimulator (Inspire Medical Systems, Inc.) | P130008<br>P130008 S126 | April 30, 2014<br>June 18, 2025 |
| Remede® System (ZOLL Respicardia, Inc.) | P160039<br>P160039 S011 | October 6, 2017<br>May 7, 2025 |
| eXciteOSA® (Spring Sleep) | K223446<br>K240328 | January 18, 2023<br>May 16, 2024 |
| Repose<br>(As of August 2011 the Repose® brand was changed to AIRvance.) | K981677 | August 27, 1999 |
| Pillar® Palatal Implant System (Medtronic Xomed Inc.) | K110623 | February 10, 2012 |

## VI. CODING

**See also:**
**Priority Health Billing Policy No. 020 – Positive Airway Pressure (PAP) Devices for Treatment of Obstructive Sleep Apnea**

**Priority Health Billing Policy No. 099 – Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea**

**Priority Health Billing Policy No. 118 – Polysomnography & Sleep Studies**

**Priority Health Billing Policy No. 141 – Surgical Treatment and Oral Appliances for Sleep Apnea: Obstructive and Central**

**ICD-10 Codes that may support medical necessity**

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|---|---|
| G47.10 – G47.19 | Hypersomnia |
| G47.30 | Sleep apnea, unspecified |
| G47.31 | Primary central sleep apnea |
| G47.33 | Obstructive sleep apnea (adult) (pediatric) |
| G47.34 | Idiopathic sleep related nonobstructive alveolar hypoventilation |
| G47.35 | Congenital central alveolar hypoventilation syndrome |
| G47.36 | Sleep related hypoventilation in conditions classified elsewhere |
| G47.37 | Central sleep apnea in conditions classified elsewhere |
| G47.39 | Other sleep apnea |
| G47.411 – G47.429 | Narcolepsy |
| G47.50 – G47.59 | Parasomnia |

| | |
|---|---|
| G47.8 | Other sleep disorders |
| G47.9 | Sleep disorder, unspecified |
| R06.00 | Dyspnea, unspecified |
| R06.09 | Other forms of dyspnea |
| R06.3 | Periodic breathing |
| R06.83 | Snoring |
| R06.89 | Other abnormalities of breathing |

**Modifier requirements for oral appliances and respiratory assist devices**

KX Modifier – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)

KX, GA, GY, GZ Modifiers – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare)

**CPT/HCPCS Codes**
*Limitations apply for Priority Health Medicare – see NCD/LCD*

Home Sleep Studies

95800 Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time [WatchPAT™ (ZOLL Itamar)]
95801 Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)
95806 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist
G0398 Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation *(Not covered for Priority Medicaid)*
G0399 Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1oxygen saturation *(Not covered for Priority Medicaid)*
G0400 Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels *(Not covered for Priority Medicaid)*

In Center Sleep Studies – Prior Authorization (PA) required
(PA not required for members < 18 years)

95805 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

95807 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
*Append modifier 52 for PAP NAP billing*

95808 Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

No prior authorization required:

94660 Continuous positive airway pressure ventilation (CPAP), initiation and management
*Consultation with a registered respiratory therapist or registered polysomnographic technologist at the time of initial treatment and or during or immediately after the initial 90 days of treatment with any of the PAP therapy devices to ensure appropriate use and fit of equipment and associated devices will be covered.*

95782 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
D9959 Unspecified sleep apnea services procedure, by report
C8009 Removal of hypoglossal nerve neurostimulator array and pulse generator
C8013 Removal of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver

*Check plan benefit limitations for surgical services –*

42140 Uvulectomy, excision of uvula
42145 Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)

Authorization Required

64568 Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

64569 Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator

64582 Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array
64583 Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator
64584 Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array *(no PA required)*

C1767 Generator, neurostimulator (implantable), non-rechargeable
C1778 Lead, neurostimulator (implantable)
C1787 Patient programmer, neurostimulator
C8007 Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring insertion of a separate distal respiratory sensor electrode or electrode array
C8008 Revision or replacement of hypoglossal nerve neurostimulator array including connection to existing pulse generator
C8011 Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components

C8012 Revision or replacement of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver

95970 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming NCD 160.18 allowed 6 dx codes; *(No PA required)*

ICD-10 Code that <u>is payable</u> for the following codes when billed by a dental provider:

G47.33 Obstructive sleep apnea (adult) (pediatric)

**CPT/HCPCS Codes:**

E0486 Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment *(Not covered for Medicaid)*

K1027 Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment *(Not covered for Medicaid)*

**Not Covered**

E0485 Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment
D9953 Reline custom sleep apnea appliance (indirect)

**Authorization required for all plans**

- *Capped rental; DME benefit*
- *Prior Authorization waived one time for the 1st three months rental. If treatment is not continued after 3 months but is resumed at a later time, prior authorization will be required from the start of treatment for the first 3 months and to continue for the following 7 months (10 months for Medicare) of the capped rental period.*
- *Requests for prior authorization must include evidence of compliance defined as use of PAP ≥4 hours per night for a minimum of 21 nights (70% of nights) during a consecutive thirty (30) day period anytime during the first three (3) months of usage.*

E0470 Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0471 Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0472 Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device) *(Not covered for Priority Medicaid)*

E0601 Continuous airway pressure (CPAP) device

A4604 Tubing with integrated heating element for use with positive airway pressure device *(Not covered for Priority Medicaid)*
A7027 Combination oral/nasal mask, used with continuous positive airway pressure device, each
A7028 Oral cushion for combination oral/nasal mask, replacement only, each
A7029 Nasal pillows for combination oral/nasal mask, replacement only, pair
A7030 Full face mask used with positive airway pressure device, each
A7031 Face mask interface, replacement for full face mask, each
A7032 Cushion for use on nasal mask interface, replacement only, each
A7033 Pillow for use on nasal cannula type interface, replacement only, pair

A7034 Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035 Headgear used with positive airway pressure device
A7036 Chinstrap used with positive airway pressure device
A7037 Tubing used with positive airway pressure device
A7038 Filter, disposable, used with positive airway pressure device
A7039 Filter, non-disposable, used with positive airway pressure device *(Not covered for Priority Medicaid)*
A7044 Oral interface used with positive airway pressure device, each
A7045 Exhalation port with or without swivel used with accessories for positive airway devices, replacement only
A7046 Water chamber for humidifier, used with positive airway pressure device, replacement, each
E0561 Humidifier, non-heated, used with positive airway pressure device
E0562 Humidifier, heated, used with positive airway pressure device

**Non-Covered CPT/HCPCS Codes:**

33276 Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed
33277 Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)
33278 Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)
33279 Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only
33280 Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only
33281 Repositioning of phrenic nerve stimulator transvenous lead(s)
33287 Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator
33288 Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)
41120 Glossectomy; less than 1/2 tongue *(not covered for sleep related conditions)*
41130 Glossectomy; hemiglossectomy *(not covered for sleep related conditions)*
41512 Tongue base suspension, permanent suture technique
41530 Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session

42160 Destruction of lesion, palate or uvula (thermal, cryo or chemical) (covered for non-sleep related indications with prior auth)
42299 Unlisted procedure, palate, uvula *(Not covered if billed for somnoplasty or any other not covered procedure. Explanatory notes must accompany claim)*

93150 Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming
93151 Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system
93152 Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography
93153 Interrogation without programming of implanted phrenic nerve stimulator system
95803 Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)

C9727 Insertion of implants into the soft palate; minimum of three implants
E0492 Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application
E0493 Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply
E0530 Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type

S2080 Laser-assisted uvulopalatoplasty (LAUP)

Unlisted Codes (*Explanatory notes must accompany claim)*

D9959 Unspecified sleep apnea services procedure, by report
E1399 Durable medical equipment, miscellaneous Not *covered for devices such as Provent® and/or other devices not recognized as covered in this policy.*

## VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

To access InterQual® guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require

prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

## VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

## IX. REFERENCES

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## SUMMARY OF CHANGES

Deletions:

- Removed coding section language stating that prior authorization was not required for DME charges less than $1,000 ($500 for Medicaid).
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Additions:

- Added a link to the related Durable Medical Equipment (DME) medical policy.

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**Past committee review dates**: 01/1993, 12/1994, 12/1995, 02/1998, 02/1999, 06/2000, 12/2001, 06/2002, 05/2003, 05/2004, 05/2005, 04/2006, 04/2007, 06/2007, 04/2008, 04/2009, 10/2009, 04/2010, 04/2011, 04/2012, 06/2012, 08/2012, 02/2013, 02/2014, 05/2014, 02/2015, 02/2016, 02/2017, 08/2017, 02/2018, 05/2018, 05/2019, 05/2020, 08/2020, 08/2021, 08/2022, 05/2023, 08/2023, 11/2023, 02/2024, 02/2025, 02/2026


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