Priority Health	BILLING POLICY No. 099
HYPOGLOSSAL NERVE STIMULATION FOR TREATMENT OF OBSTRUCTIVE SLEEP APNEA	
Date of origin: June 19, 2025	**Review dates: 7/2025, 8/2025, 8/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards.

This policy identifies billing and payment requirements associated with Hypoglossal Nerve Stimulation for the treatment of Obstructive Sleep Apnea.

DEFINITION

- **Hypoglossal nerve stimulation (HGNS)**: Hypoglossal nerve stimulation is used to treat moderate to severe obstructive sleep apnea in cases where the CPAP isn't effective or not tolerated. It's made up of three implantable components. It works by stimulating the hypoglossal nerve to keep the airway open during sleep.
- **Hypoglossal nerve**: The hypoglossal nerve is the twelfth cranial nerve and innervates all the extrinsic and intrinsic muscles of the tongue.
- **Obstructive Sleep Apnea (OSA)**: Obstructive sleep apnea is a disease characterized by recurrent episodes of upper airway obstruction during sleep.
- **Continuous positive airway pressure (CPAP)**: The CPAP machine is used to treat sleep apnea. It delivers continuous air to keep the airways open during sleep.

MEDICAL POLICY

- Sleep Apnea: Obstructive & Central (#91333)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD, or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding Specifics

This service is for members 18 years of age or older.

- Don't bill CPT code 64582 in conjunction with 64583, 64584 or 61888
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- Don't bill CPT code 64584 in conjunction with 64582, 64583 or 61888
- Don't bill CPT code 64568 in conjunction with 61885, 61886 or 64570
- Don't bill CPT code 64569 in conjunction with 64570 or 61888
- Don't bill CPT code 64570 in conjunction with 61888

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier noted below may not be all-inclusive. Learn more about modifier use in our Provider Manual.

- **52**: Use modifier 52 for removal of one or two components of the hypoglossal nerve stimulator electrode array, pulse generator or distal respiratory sensor, and bill at a reduced rate.

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Diagnosis Sequencing

When hypoglossal nerve stimulation is reported with a diagnosis of obstructive sleep apnea (G47.33), a secondary diagnosis to indicate body mass index less than 35 kg/m2 (Z68.1-Z68.34) must also be reported.

This is in alignment with our Medical Policy:

Inclusion criteria (must meet ALL):

- Age ≥ 18 years
- Diagnosis of OSA made using an in-lab polysomnography (PSG) or validated home sleep test within 24 months of first consultation for Inspire implant
- Body Mass Index (BMI) < 35 kg/m2
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Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

Related denial language
E4B – Missing diagnosis code

REFERENCES

- LCA – A57944 Billing and Coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (CMS)
- LCD – L38528 Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (CMS)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry-standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
July 9, 2025	Correction: This service is for members 18 years of age and older (not 22 as previously stated). This aligns with our existing medical policy: Sleep Apnea: Obstructive & Central (#91333)
Aug. 14, 2025	Added "Diagnosis sequencing" section
Aug. 19, 2026	Added "Overview" section.