Priority Health

MEDICAL POLICY
No. 91333-R31

SLEEP APNEA: OBSTRUCTIVE & CENTRAL

Including Uvulopalatopharyngoplasty (UPPP) and Laser - Assisted Uvulopalatoplasty (LAUP)

Effective Date: February 21, 2024	**Review Dates: 1/93, 12/94, 12/95, 2/98, 2/99, 6/00, 12/01, 6/02, 5/03, 5/04, 5/05, 4/06, 4/07, 6/07, 4/08, 4/09, 10/09, 4/10, 4/11, 4/12, 6/12, 8/12, 2/13, 2/14, 5/14, 2/15, 2/16, 2/17, 8/17, 2/18, 5/18, 5/19, 5/20, 8/20, 8/21, 8/22, 5/23, 8/23, 11/23, 02/24, 2,25**
Date Of Origin: June 30, 1988	**Status: Current**

I. POLICY/CRITERIA

Special Note: This policy applies to *adults* age 18 and older only.

A. Testing and Diagnosis

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

   - Facility-Based Polysomnogram (PSG) (Prior Authorization required for members ≥ 18 years)
   - Facility-Based Titration Study (Prior Authorization required for members ≥ 18 years)
   - 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 OSA

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.
      - Bilevel Positive Airway Pressure (BPAP), Demand Positive Airway Pressure (DPAP), and Variable Positive Airway Pressure (VPAP) are covered as DME.
      - Humidifiers and heaters for positive airway pressure devices are covered.

- 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:

      - AHI>5 and <15
      - >20 episodes of oxygen desaturation < 85% or any one episode of oxygen desaturation < 70%
      - Type II second degree heart block or pause > 3 seconds or ventricular tachycardia at a rate > 140/minute lasting > 15 complexes
      - 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) and a covered benefit when ***ALL*** of the inclusion criteria are met, **NONE** of the contraindications are present, and the provider meets specified qualifications:

1. Inclusion criteria (must meet ***ALL***):

   a. Age ≥ 18 years
   b. Body Mass Index (BMI) < 35 kg/m^2

c. Diagnosis of OSA made using an in-lab polysomnography (PSG) or validated home sleep test within 24 months of first consultation for Inspire implant
d. Moderate to severe obstructive sleep apnea (OSA) characterized as follows:

    i. Apnea Hypopnea Index (AHI) between 15 and 65 events/h
    ii. < 25% central and mixed apneas

e. Documentation that demonstrates one of the following:

    i. Continuous Positive Airway Pressure (CPAP) failure (defined as AHI > 15 despite CPAP usage); ***OR***
    ii. CPAP intolerance (defined as < 4 hours per night, 5 nights per week or the CPAP has been returned) including shared decision making that the patient was intolerant of CPAP despite consultation with a sleep expert

f. One of the following:

    i. Documented trial and failure of mandibular advancement device (MAD); OR
    ii. Documented contraindication(s) for oral appliance therapy. Examples include, but are not limited to, the following:

        - Temporomandibular joint disease
        - Periodontal disease
        - Insufficient dentition
        - Inadequate jaw range of motion
        - Severe obstructive sleep apnea (AHI or Respiratory Event Index (REI) > 30)

g. Absence of complete concentric collapse at the soft palate level as seen on a drug-induced sleep/sedated endoscopy (DISE) procedure
h. No other anatomical findings that would compromise performance of device (e.g., tonsil size 3 or 4 per standardized tonsillar hypertrophy grading scale).

2. Contraindications (must exhibit ***NONE***):

    a. Central + mixed apneas > 25% of the total apnea-hypopnea index (AHI)
    b. Any anatomical finding that would compromise the performance of upper airway stimulation, such as the presence of complete concentric collapse of the soft palate

c. Any condition or procedure that has compromised neurological control of the upper airway
d. Unable or does not have the necessary assistance to operate the sleep remote
e. Pregnant or plans to become pregnant
f. Implantable device that may be susceptible to unintended interaction with the Inspire system.
g. BMI ≥ 35
h. Neuromuscular disease
i. Hypoglossal-nerve palsy
j. Severe restrictive or obstructive pulmonary disease
k. Moderate-to-severe pulmonary arterial hypertension
l. Severe valvular heart disease
m. New York Heart Association (NYHA) class III or class IV heart failure
n. Recent myocardial infarction or severe cardiac arrhythmias (within the past 6 months)
o. Persistent uncontrolled hypertension despite medication use.
p. An active, serious mental illness that reduces the ability to carry out Activities of Daily Living (ADLs) and would interfere with the patient's ability to operate the HNS and report problems to the attending provider.

3. Provider qualifications:

a. Insertion of an FDA-approved hypoglossal nerve stimulation device must be performed by a qualified physician:

i. Completed the appropriate AMA or AOA-certified residency program in otolaryngology
ii. Received classroom instruction by an FDA-approved device manufacturer or equivalent on device implantation techniques (documentation attesting to completion of such training shall be furnished if requested by Priority Health).

b. Shared decision shall be documented in the patient's record by both the referring physician and the implanting physician—such documentation will be provided if requested.

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.

   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.

Definitions:

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 $\geq$30 events without symptoms or $\geq$10 events with symptoms).

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.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, 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, please refer to the Priority Health Provider Manual.

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

III. APPLICATION TO PRODUCTS

Coverage is subject to 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) and/or the Evidence of Coverage (EOC); 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 located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, 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.***

IV. DESCRIPTION

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 treatment of snoring alone is not a covered benefit. There must be objective evidence of sleep

apnea on polysomnography or Multiple Sleep Latency Test for coverage of treatment. Testing for OSA is a covered benefit

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.

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.

V. CODING INFORMATION

ICD-10 Codes that may apply:

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)

Covered CPT/HCPCS Codes when policy criteria met:
Limitations apply for Priority Health Medicare – see 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

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

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)

<u>Authorization required for all plans</u>
- *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

No PA required if charge amount less than $1,000 ($500 for Medicaid)
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.*

VI. REFERENCES

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