OBSTRUCTIVE SLEEP APNEA
Including Uvulopalatopharyngoplasty (UPPP) and Laser - Assisted Uvulopalatoplasty (LAUP)

Effective Date: July 1, 2019
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
Date Of Origin: June 30, 1988
Status: Current

Summary of Changes

Additions:
- Inclusion criteria and contraindications for the Inspire Upper Airway Hypoglossal Nerve Stimulator (Inspire Medical Systems, Inc.) for treatment of obstructive sleep apnea.

I. POLICY/CRITERIA

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

A. Testing and Diagnosis

All studies (with the exception of home sleep studies) require prior authorization. The studies must be done by a certified sleep lab facility and be read by a certified sleep specialist. There are no limitations on referrals to in-network sleep specialists. Prior authorization is not required for ages younger than 18 years.

1. Home/portable sleep apnea studies (HSAT) are considered medically necessary for individuals clinically suspected of having obstructive sleep apnea (OSA), and who do not have any of the following:

   a. HF (heart failure) NYHA Class III and IV, EF (Ejection Fraction) < 50%, or Class II Diastolic Dysfunction
   b. Cardiac arrhythmia (e.g. atrial fibrillation, SVT, ventricular arrhythmia)
   c. History of myocardial infarction or coronary artery disease in last 12 months
   d. Moderate to severe pulmonary disease (e.g., chronic respiratory disease, symptomatic lung disease, pulmonary hypertension)
   e. Neuromuscular disease
   f. Stroke or TIA within the last 12 months
   g. Cognitive impairment, behavioral health issues or other social circumstances that compromise administration of a home sleep test (HST)
h. Seizure disorder

Prior authorization is not required for home sleep apnea studies and may be ordered by any licensed physician or advanced practice provider.

In addition to meeting criteria in #1 above, evaluation using HSAT is covered if clinical interpretation is performed by a board certified sleep specialist and HSAT is provided by Medicare certified participating provider with a device described below.

Unattended (home) sleep studies using any of the following diagnostic techniques is medically necessary for members with symptoms suggestive of OSA when the home sleep study is used as part of a comprehensive sleep evaluation:

a. Sleep monitoring using a Type II device, or
b. Sleep monitoring using a Type III device, or
c. Sleep monitoring using a Type IV(A) device, measuring airflow and at least 2 other channels and providing measurement of apnea-hypopnea index (AHI)

Note: Sleep studies using devices that do not provide a measurement of apnea-hypopnea index (AHI) and oxygen saturation are considered not medically necessary because they do not provide sufficient information to prescribe treatment. Examples include the Biancamed SleepMinder, SNAP testing with fewer than three channels, and the SleepImage Sleep Quality Screener. Note that the ApneaLink does not meet criteria as a covered type IV device because it does not measure airflow; however, the ApneaLink Plus records 5 channels, including airflow, and meets criteria for a covered sleep study device.

2. Attended sleep studies or polysomnogram (PSG) may be considered medically necessary for individuals with suspected OSA as determined by clinical symptoms and one of the following:

a. Any of the clinical symptoms outlined in (a - h) in 1 above; or
b. Two failed, incomplete, or inadequate HSATs with significant indicators of OSA; or
c. One technically complete or adequate negative HSAT with high suspicion of OSA (presumptive false negative); or
d. On patients who demonstrate Cheyne-Stokes Respiration (CSR) on HSAT

3. Split-night studies: If clinically appropriate, a split-night diagnostic protocol, rather than a full-night diagnostic protocol for PSG, may be used in the diagnosis of OSA. Clinically appropriate is defined as the absence
of conditions identified by the clinician that are likely to interfere with successful diagnosis and treatment using a split-night protocol.

In the event that moderate to severe OSA was not anticipated prior to ordering PSG, and to ensure safety during PSG, conversion to a Split Night Study is considered medically necessary if all criteria below are met:

a. OSA is diagnosed by apnea/hypopnea index (AHI) as defined below on PSG.

b. Oxygen desaturation as defined by SaO₂ <85% is present during PSG.

c. Member has been counseled in sleep related respiratory events (apnea, hypopnea, sleep arousal, AHI) and the mechanics of PAP therapy for the treatment of OSA have been reviewed.

d. Criteria to allow for a split-night study have been reviewed with the patient in advance of PSG.

A split-night study is not considered medically necessary if documentation of a specific treatment plan exists that does not include CPAP therapy. Examples include:

- a planned referral to a dentist for a mandibular advancement appliance,
- plans for upper airway surgery, or
- a statement that the patient does not want any treatment until the results of the test are reviewed by the sleep specialist.

4. Attended sleep studies or polysomnogram (PSG) may be considered medically necessary when a certified sleep specialist suspects one of the following sleep disorders prior to PSG:

   a. narcolepsy
   b. idiopathic hypersomnia
   c. clinically significant parasomnia disorders (including nocturnal seizures)
   d. central sleep apnea
   e. obesity hypoventilation syndrome with BMI >45. And hypoventilation with documented hypoxia
   f. periodic limb movement disorder (PLMD): The following additional criteria apply:

   There must be complaints, by the patient or an observer, of repetitive limb movements during sleep, and:

   a. frequent awakenings, or
MEDICAL POLICY
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Obstructive Sleep Apnea
Including UPPP and LAUP

b. fragmented sleep, or
c. difficulty maintaining sleep, or
d. excessive daytime sleepiness,

Additionally, the patient must have at least one additional risk factor for PLMD, including, but not limited to, the following:

a. iron deficiency anemia
b. renal disease
c. medication that cannot be discontinued (e.g., antidepressant, antipsychotic, sedating antihistamine)
d. spinal injury
e. peripheral neuropathy
f. diabetes mellitus

Exception: If the patient is currently being treated for diagnosed OSA, the criterion for an additional risk factor for PLMD does not apply.

5. Repeat facility-based PSG are a covered benefit when the above criteria in #2 for a PSG are met and for evaluation of one of the following:

a. the discontinuation of PAP or oral appliance after surgery (oral surgery, UPPP); or
b. resolution of OSA after surgical treatment for OSA (oral surgery, UPPP); or

6. CPAP Titration Studies may be covered if any of the following criteria are present:

- Moderate to severe pulmonary disease (e.g. chronic respiratory disease / symptomatic lung disease / pulmonary hypertension)
- Congestive heart failure or recent MI within the last 6 months
- Cognitive impairment that compromises administration of a home apnea sleep test (HSAT)
- OSA with severe desaturation (oxygen desaturations either a) >5 continuous minutes with SaO2 <87% or b) 5 total minutes with SaO2 <80%)
- Other comorbid sleep disorder as listed in 4 above, in addition to OSA
- Failure of home APAP titration
7. PAP-NAP (95807-52, involving mask fit, patient desensitization and leak control during a daytime nap while monitoring airflow, respiratory effort, EKG and oximetry) in a patient diagnosed with sleep apnea using in center or HSAT testing and meeting criteria for PAP prescription is covered in the following situations:

   a. In patients prescribed PAP who have less than 70% compliance in the first 30 days of use; or
   b. In patients unable to tolerate home titration (i.e. moderate to severe mental illness, cognitive impairment, claustrophobia, insomnia < 6 hours of sleep).

8. The Multiple Sleep Latency Test (MSLT) is covered according to InterQual® criteria.

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 (Inspire Upper Airway Hypoglossal Nerve Stimulator)

The 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 and NONE of the contraindications are present:

1. Inclusion criteria (must meet ALL):
   a. Age ≥ 22 years
   b. Body Mass Index (BMI) ≤ 32 kg/m²
   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 apneas
   e. ONE of the following:
      i. Minimum of 1 month of Continuous Positive Airway Pressure (CPAP) monitoring documentation that demonstrates CPAP failure (defined as AHI > 15 despite CPAP usage); OR
      ii. CPAP intolerance (defined as < 4 hours per night, 5 nights per week)
   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)

b. Absence of complete concentric collapse at the soft palate level as seen on a drug-induced sleep/sedated endoscopy (DISE)

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.

**Note:** Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (Inspire Upper Airway Hypoglossal Nerve Stimulator) is NOT covered for:

- Medicaid/Healthy Michigan Plan/MIChild members
- Medicare members

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.

**Definitions:**

The Apnea/Hypopnea Index (AHI) is determined by attended polysomnography, equal to the total number of 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).

**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

☒ Required:
  • For hypoglossal nerve stimulation device
  • For in-center sleep testing and capped rental positive pressure appliances (see below)

☒ Not Required – for home sleep testing, surgery; PAP supplies and oral appliances - unless DME/P&O dollar threshold exceeded (greater than $1,000; $500 for Priority Health Medicaid – based on claim charge amount).

☐ Not Applicable

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.
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):

- 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.
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

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
- 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
- G0399 Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen 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 0 – 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

Check plan benefit limitations for surgical services – 42140 Uvulectomy, excision of uvula
42145  Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)

Authorization Required

64568  Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator  (Not covered for Medicaid or Medicare for Inspire®)

64569  Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator (Not covered for Medicaid or Medicare for Inspire®)

0466T  Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (List separately in addition to code for primary procedure) (Not covered for Medicaid or Medicare)

0467T  Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator (Not covered for Medicaid or Medicare)

0468T  Removal of chest wall respiratory sensor electrode or electrode array (Not covered for Medicaid or Medicare, no PA required)

C1767  Generator, neurostimulator (implantable), nonrechargeable (Not covered for Medicaid for Inspire®)

C1778  Lead, neurostimulator (implantable) (Not covered for Medicaid for Inspire®)

C1787  Patient programmer, neurostimulator (Not covered for Medicaid for Inspire®)
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, Not covered for Medicaid for Inspire®)

ICD-10 Code that is payable 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 Priority Medicaid)

Not covered
E0485  Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment

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

No PA required if charge amount less than $1,000 (% 00 for Medicaid)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4604</td>
<td>Tubing with integrated heating element for use with positive airway pressure device</td>
</tr>
<tr>
<td>A7027</td>
<td>Combination oral/nasal mask, used with continuous positive airway pressure device, each</td>
</tr>
<tr>
<td>A7028</td>
<td>Oral cushion for combination oral/nasal mask, replacement only, each</td>
</tr>
<tr>
<td>A7029</td>
<td>Nasal pillows for combination oral/nasal mask, replacement only, pair</td>
</tr>
<tr>
<td>A7030</td>
<td>Full face mask used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7031</td>
<td>Face mask interface, replacement for full face mask, each</td>
</tr>
<tr>
<td>A7032</td>
<td>Cushion for use on nasal mask interface, replacement only, each</td>
</tr>
<tr>
<td>A7033</td>
<td>Pillow for use on nasal cannula type interface, replacement only, pair</td>
</tr>
<tr>
<td>A7034</td>
<td>Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap</td>
</tr>
<tr>
<td>A7035</td>
<td>Headgear used with positive airway pressure device</td>
</tr>
<tr>
<td>A7036</td>
<td>Chinstrap used with positive airway pressure device</td>
</tr>
<tr>
<td>A7037</td>
<td>Tubing used with positive airway pressure device</td>
</tr>
<tr>
<td>A7038</td>
<td>Filter, disposable, used with positive airway pressure device</td>
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<tr>
<td>A7039</td>
<td>Filter, non-disposable, used with positive airway pressure device</td>
</tr>
<tr>
<td>A7044</td>
<td>Oral interface used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7045</td>
<td>Exhalation port with or without swivel used with accessories for positive airway devices, replacement only</td>
</tr>
<tr>
<td>A7046</td>
<td>Water chamber for humidifier, used with positive airway pressure device, replacement, each</td>
</tr>
<tr>
<td>E0561</td>
<td>Humidifier, non-heated, used with positive airway pressure device</td>
</tr>
<tr>
<td>E0562</td>
<td>Humidifier, heated, used with positive airway pressure device</td>
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**Non-covered CPT/HCPCS Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95803</td>
<td>Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)</td>
</tr>
<tr>
<td>41120</td>
<td>Glossectomy; less than 1/2 tongue <em>(not covered for sleep related conditions)</em></td>
</tr>
<tr>
<td>41130</td>
<td>Glossectomy; hemiglossectomy <em>(not covered for sleep related conditions)</em></td>
</tr>
<tr>
<td>41512</td>
<td>Tongue base suspension, permanent suture technique</td>
</tr>
<tr>
<td>41530</td>
<td>Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session</td>
</tr>
<tr>
<td>42160</td>
<td>Destruction of lesion, palate or uvula (thermal, cryo or chemical) <em>(covered for non-sleep related indications with prior auth)</em></td>
</tr>
<tr>
<td>42299</td>
<td>Unlisted procedure, palate, uvula <em>(Not covered if billed for somnoplasty or any other not covered procedure. Explanatory notes must accompany claim)</em></td>
</tr>
<tr>
<td>C9727</td>
<td>Insertion of implants into the soft palate; minimum of three implants</td>
</tr>
<tr>
<td>S2080</td>
<td>Laser-assisted uvulopalatoplasty (LAUP)</td>
</tr>
<tr>
<td>E0190</td>
<td>Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories</td>
</tr>
<tr>
<td>E1399</td>
<td>Durable medical equipment, miscellaneous <em>(Explanatory notes must accompany claim)</em></td>
</tr>
</tbody>
</table>

*Not covered for devices such as Provent® and/or other devices not recognized as covered in this policy.*
0424T Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)

0425T Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only

0426T Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only

0427T Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only

0428T Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only

0429T Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only

0430T Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only

0431T Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only

0432T Repositioning of neurostimulator system for treatment of central sleep apnea, pulse generator only

0433T Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only

0434T Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only

0435T Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea

0436T Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session

0437T Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study

VI. REFERENCES


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