


MEDICAL POLICY		Sleep Disorder Treatment: Surgical (Medicare Only)	
Effective Date: 12/1/2020		Section: SUR	Policy No: 442
 12/1/2020		Medical Policy Committee Approved Date: 9/19; 2/2020; 10/2020	
Medical Officer	Date		

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Services (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Sleep Disorder Treatments: Surgical</i>	<ul style="list-style-type: none"> Local Coverage Determination (LCD): Surgical Treatment of Obstructive Sleep Apnea (OSA) (L34526).¹ Local Coverage Article: Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA) (A56905)²
<i>Hypoglossal Nerve Stimulation</i>	<ul style="list-style-type: none"> Local Coverage Determination (LCD): Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38312).³ Local Coverage Article: Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A57949)⁴

Per the [Medicare Policy Manual](#) commercial medical policies may be applied to Medicare coverage determinations in the absence of an appropriate NCD, LCD, LCA, or CMS Coverage Manual. Therefore, the commercial medical policy, **Sleep Disorder Treatment: Surgical (All Lines of Business except Medicare)** applies to the following services:

- Removal or Replacement of Hypoglossal Nerve Stimulator

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BILLING GUIDELINES

Please see the following Local Coverage Articles for applicable billing guidelines:

- Local Coverage Article: Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA) ([A56905](#))²
- Local Coverage Article: Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea ([A57949](#))⁴

Laser-assisted Uvulopalatoplasty

LAUP must not be billed as 42145, Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty). This code is not appropriate for this procedure. If LAUP is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "LAUP" in the electronic narrative 2400/SV101-7 equivalent to line 19 of the CMS 1500 form.

Somnoplasty™

Somnoplasty™ is a trade name for palate reduction with the Somnoplasty™ System of Somnus Medical Systems. Somnoplasty™ must not be billed as 42145. This code is not appropriate for this procedure. If Somnoplasty™ is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "Somnoplasty™" in the electronic narrative 2400/SV101-7 equivalent to line 19 of the CMS 1500 form.

Pillar Procedure™

The Pillar Procedure™ is a trade name for palatal implants. This procedure should be billed by the physician as 42299 (unlisted procedure, palate, uvula) with "Pillar Procedure™" or "palatal implant" in the electronic narrative 2400/SV101-7 equivalent to line 19 of the CMS 1500 form. Hospital outpatient would use code C9727.

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
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)
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator
0468T	Removal of chest wall respiratory sensor electrode or electrode array

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21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21141	Reconstruction midface, lefort i; single piece, segment movement in any direction (eg, for long face syndrome), without bone graft
21145	Reconstruction midface, lefort i; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21685	Hyoid myotomy and suspension
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
No Prior Authorization Required	
30140	Submucous resection inferior turbinate, partial or complete, any method
31600	Tracheostomy, planned (separate procedure);
31610	Tracheostomy, fenestration procedure with skin flaps
Not Covered	
41512	Tongue base suspension, permanent suture technique
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session
C9727	Insertion of implants into the soft palate; minimum of three implants
S2080	Laser-assisted uvulopalatoplasty (laup)
Unlisted Procedure	
All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then prior-authorization is required.	
42299	Unlisted procedure, palate, uvula

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

REFERENCES

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Surgical Treatment of Obstructive Sleep Apnea (OSA) (L34526). Revision effective date, 11/1/2019. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34526>. Published 2018. Accessed 7/30/2020.
2. Centers for Medicare & Medicaid Services. Local Coverage Article: Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA) (A56905). Revision effective date, 11/1/2019. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=56905>. Accessed 7/30/2020.
3. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38312). Effective date, 3/15/2020. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=38312>. Published 2019. Accessed 7/30/2020.
4. Centers for Medicare & Medicaid Services. Local Coverage Article: Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A57949). Effective date, 3/15/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57949>. Accessed 7/30/2020.