MEDICAL POLICY

Sleep Disorder Treatment: Surgical (Medicare Only)

Effective Date: 12/1/2020

Section: SUR  
Policy No: 442

Medical Policy Committee Approved Date: 9/19; 2/2020; 10/2020

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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare Guidelines</th>
</tr>
</thead>
</table>
| Sleep Disorder Treatments: Surgical          | • 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])\(^2\) |
| Hypoglossal Nerve Stimulation                | • 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
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])
- Local Coverage Article: Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea ([A57949])

*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**

<table>
<thead>
<tr>
<th>Medicare Only</th>
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<tbody>
<tr>
<td><strong>Prior Authorization Required</strong></td>
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<tr>
<td><strong>0466T</strong></td>
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<td><strong>0467T</strong></td>
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<td><strong>0468T</strong></td>
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</tbody>
</table>
### MEDICAL POLICY

#### Sleep Disorder Treatment: Surgical

*(Medicare Only)*

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>21110</td>
<td>Application of interdental fixation device for conditions other than fracture or dislocation, includes removal</td>
</tr>
<tr>
<td>21141</td>
<td>Reconstruction midface, lefort i; single piece, segment movement in any direction (eg, for long face syndrome), without bone graft</td>
</tr>
<tr>
<td>21145</td>
<td>Reconstruction midface, lefort i; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)</td>
</tr>
<tr>
<td>21196</td>
<td>Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation</td>
</tr>
<tr>
<td>21199</td>
<td>Osteotomy, mandible, segmental; with genioglossus advancement</td>
</tr>
<tr>
<td>21685</td>
<td>Hyoid myotomy and suspension</td>
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<tr>
<td>30802</td>
<td>Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)</td>
</tr>
<tr>
<td>42145</td>
<td>Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)</td>
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<tr>
<td>64568</td>
<td>Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td>
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</table>

**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.
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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**


