


<b>MEDICAL POLICY</b>	<b>Sleep Disorder Treatment: Surgical (Medicare Only)</b>
<b>Effective Date: 10/1/2021</b>   10/1/2021	Medical Policy Number: 244
	Medical Policy Committee Approved Date: 9/19; 2/2020; 10/2020; 9/2021
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"> <li>Local Coverage Determination (LCD): Surgical Treatment of Obstructive Sleep Apnea (OSA) (<a href="#">L34526</a>).<sup>1</sup></li> <li>Local Coverage Article: Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA) (<a href="#">A56905</a>)<sup>2</sup></li> </ul>
<i>Hypoglossal Nerve Stimulation</i>	<ul style="list-style-type: none"> <li>Local Coverage Determination (LCD): Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (<a href="#">L38312</a>).<sup>3</sup></li> <li>Local Coverage Article: Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (<a href="#">A57949</a>)<sup>4</sup></li> </ul>

*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

<b>MEDICAL POLICY</b>	<b>Sleep Disorder Treatment: Surgical (Medicare Only)</b>
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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](#))<sup>2</sup>
- Local Coverage Article: Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea ([A57949](#))<sup>4</sup>

### *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

<b>MEDICAL POLICY</b>	<b>Sleep Disorder Treatment: Surgical (Medicare Only)</b>
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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
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, lefort i; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21685	Hyoid myotomy and suspension
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)
42120	Resection of palate or extensive resection of lesion
42140	Uvulectomy, excision of uvula
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
42235	Repair of anterior palate, including vomer flap
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
<b>No Prior Authorization Required</b>	
30140	Submucous resection inferior turbinate, partial or complete, any method
31600	Tracheostomy, planned (separate procedure);
31610	Tracheostomy, fenestration procedure with skin flaps
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)
42225	Palatoplasty for cleft palate; attachment pharyngeal flap
42226	Lengthening of palate, and pharyngeal flap
<b>Not Covered</b>	
41512	Tongue base suspension, permanent suture technique

<b>MEDICAL POLICY</b>	<b>Sleep Disorder Treatment: Surgical (Medicare Only)</b>
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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)
<b>Unlisted Procedure</b> 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 <b>prior-authorization is required.</b>	
41599	Unlisted procedure, tongue, floor of mouth
42299	Unlisted procedure, palate, uvula
64999	Unlisted procedure, nervous system

## 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. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

## REFERENCES

- Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Surgical Treatment of Obstructive Sleep Apnea (OSA) (L34526). Revision effective date 7/29/2021. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34526>. Accessed 8/2/2021.
- Centers for Medicare & Medicaid Services. Local Coverage Article: Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA) (A56905). Revision effective date. 7/29/2021.

**MEDICAL POLICY****Sleep Disorder Treatment: Surgical  
(Medicare Only)**

<https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=56905>.

Accessed 8/2/2021.

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>. Accessed 8/2/2021.
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. 10/1/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57949>. Accessed 8/2/2021.