Sleep Apnea Surgical Treatments

Policy Number: MMP087.10
Last Committee Approval Date: June 12, 2024
Effective Date: August 1, 2024

➲ Instructions for Use

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Related Commercial Medical Policy
• Obstructive and Central Sleep Apnea Treatment

Coverage Rationale

Radiofrequency Submucosal Ablation of the Soft Palate and/or Tongue Base

Medicare does not have a National Coverage Determination (NCD) for radiofrequency submucosal ablation of the soft palate and/or tongue base. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Radiofrequency Submucosal Ablation of the Soft Palate and/or Tongue Base.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Obstructive and Central Sleep Apnea Treatment.

Other Surgical Treatments for Obstructive Sleep Apnea (OSA)

Medicare does not have a National Coverage Determination (NCD) for other surgical treatments of OSA. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Other Surgical Treatments for Obstructive Sleep Apnea (OSA).

For coverage guidelines for states/territories with no LCDs/LCAs, refer the UnitedHealthcare Commercial Medical Policy titled Obstructive and Central Sleep Apnea Treatment.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Absent language indicating that a code is non-covered, listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
21685	Hyoid myotomy and suspension
41512	Tongue base suspension, permanent suture technique
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session
41599	Unlisted procedure, tongue, floor of mouth
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD or LCA is found refer to the criteria as noted in the Coverage Rationale section above

NCD	LCD	LCA	Contractor Type	Contractor Name
Radiofrequency Submucosal Ablation of the Soft Palate and/or Tongue Base				
N/A	L34526 Surgical Treatment of Obstructive Sleep Apnea (OSA)	A56905 Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA)	Part A and B MAC	WPS*
Other Surgical Treatments for Obstructive Sleep Apnea (OSA)				
N/A	L34526 Surgical Treatment of Obstructive Sleep Apnea (OSA)	A56905 Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA)	Part A and B MAC	WPS*

Medicare Administrative Contractor (MAC) with Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
*__Note__: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers	

Policy History/Revision Information

Date	Summary of Changes

08/01/2024	**Title Change/Template Update**
	• Previously titled *Sleep Apnea Diagnosis and Treatment*
	• Reformatted and reorganized policy; transferred content to new template
	• Changed policy type classification from “Coverage Summary” to “Medical Policy”
	• Updated *Instructions for Use*
	Related Policies
	• Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Obstructive and Central Sleep Apnea Treatment*
	• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Sleep Testing for Obstructive Sleep Apnea (OSA) (NCD 240.4.1)*
	Coverage Rationale
	• Removed notation pertaining to the face-to-face encounter requirement for durable medical equipment (Affordable Care Act §6407)
	• Removed content/language addressing:
	  ○ Diagnosis of obstructive sleep apnea (OSA)
	  ○ Polysomnography and sleep studies
	  ○ Home sleep studies (HCPCS codes G0398, G0399, and G0400 and CPT codes 95800, 95801, and 95806)
	  ○ Treatment of obstructive sleep apnea (OSA)

Date	Summary of Changes
	○ Continuous positive airway pressure (CPAP) ○ Coverage with evidence development (CED) ○ Respiratory assist devices including bilevel positive airway pressure (BiPAP) ○ Mandibular devices/oral appliances ○ Implantable hypoglossal nerve stimulation (HGNS) [e.g., Inspire® Upper Airway Stimulation and the aura6000™ Sleep Therapy System] (CPT codes 64569, 64570, 64582, 64583, and 64584) **Centers for Medicare & Medicaid (CMS) Related Documents** • Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* **Supporting Information** • Archived previous policy version MCS087.09

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.