ASURIS NORTHWEST HEALTH

Medicare Advantage Policy Manual **Policy ID:** M-SUR166

Surgeries for Snoring, Obstructive Sleep Apnea Syndrome, and Upper Airway Resistance Syndrome

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Obstructive sleep apnea (OSA) is defined as repeated periods of complete airway obstruction (apnea) lasting at least 10 seconds during sleep. Hypopnea, partial airway obstruction with at least 30% reduction in airflow for 10 seconds or more, may also be present. The gold standard test used to diagnose OSA a polysomnogram performed in a sleep laboratory. Polysomnography monitors document the number of apneic and hypopneic events per hour and combine them into the apnea-hypopnea index (AHI). Non-surgical management (e.g., weight loss, various continuous positive airway pressure [CPAP] devices, or orthodontic repositioning devices, etc.) is considered the first-line treatment for OSA and upper airway

resistance syndrome (UARS). However, surgical intervention may be considered after non-surgical treatments have failed.

MEDICARE ADVANTAGE POLICY CRITERIA

CMS Coverage Manuals*	None
National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	None
Medical Policy Manual	*Medicare coverage guidance is not available for surgical procedures for snoring and OSA. Therefore, the health plan's medical policy is applicable.* Surgeries for Snoring, Obstructive Sleep Apnea Syndrome, and Upper Airway Resistance Syndrome, Surgery, Policy No. 166 *(see "NOTE" below)*

NOTE: If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. (*Medicare IOM Pub. No. 100-04, Ch. 23, §30 A*). According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an ***objective, evidence-based process, based on authoritative evidence***. (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan's evidence-assessment process (see Cross References).

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- History and Physical/Chart Notes
- Current Symptomology
- Conservative Medical Therapies failed
- CPAP Trial results
- Sleep Study results
- Documentation of an adequate trial of a mandibular repositioning device or documentation that the patient is not an appropriate appliance candidate with clinical rationale

- Evidence of airway obstruction or narrowing consistent with the procedure requested

CROSS REFERENCES

Investigational (Experimental) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services, Medicine, Policy No. M-149

Orthognathic Surgery, Surgery, Policy No. M-137

Phrenic Nerve Stimulation for Central Sleep Apnea, Surgery, Policy No. M-212

Hypoglossal Nerve Stimulation, Surgery, Policy No. M-215

REFERENCES

None

CODING

NOTE: There is no specific CPT code for the tongue base reduction procedure. The most appropriate code to use is 41599 (unlisted procedure) or 41530. CPT 41120 (partial glossectomy) describes a surgical resection and is not the appropriate code to use for submitting claims for tongue base reduction.

Codes	Number	Description
CPT	21121	Genioplasty; sliding osteotomy, single piece
	21122	Genioplasty; sliding osteotomies, two or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
	21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., 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
	21198	Osteotomy, mandible, segmental;
	21199	Osteotomy, mandible, segmental; with genioglossus advancement
	21685	Hyoid myotomy and suspension
	41120	Glossectomy; less than one-half tongue
	41512	Tongue base suspension, permanent suture technique
	41530	Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session
	41599	Unlisted procedure, tongue, floor of mouth
	42140	Uvulectomy, excision of uvula
	42145	Palatopharyngoplasty (eg, Uvulopalatopharyngoplasty, Uvulopharyngoplasty)

Codes	Number	Description
	42160	Destruction of lesion, palate or uvula (thermal, cryo, or chemical)
	42299	Unlisted procedure, palate, uvula
HCPCS	S2080	Laser-assisted uvulopalatoplasty (LAUP) *(Not recognized by Medicare for payment)*

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*