**Coverage Summary**

**Sleep Apnea: Diagnosis and Treatment**

- **Policy Number:** S-003  
  - **Products:** UnitedHealthcare Medicare Advantage Plans
  - **Original Approval Date:** 08/23/2007
  - **Approved by:** UnitedHealthcare Medicare Benefit Interpretation Committee
  - **Last Review Date:** 09/18/2018

**Related Medicare Advantage Policy Guidelines:**
- [Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)](NCD 240.4)
- [Electrosleep Therapy](NCD 30.4)
- [Sleep Testing for Obstructive Sleep Apnea (OSA)](NCD 240.4.1)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

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**INDEX TO COVERAGE SUMMARY**

I. **COVERAGE**

   1. Diagnosis of Obstructive Sleep Apnea (OSA)
      - a. Oximetry Testing
      - b. Polysomnography and Sleep Studies

   2. Treatment of Sleep Apnea
      - a. Continuous Positive Airway Pressure (CPAP)
      - b. Respiratory Assist Devices including Bilevel Positive Airway Pressure (BiPAP)
      - c. Mandibular Devices/Oral Appliances
      - d. Electrosleep Therapy
      - e. Surgical Treatment
         1) Radiofrequency Submucosal Ablation of the Soft Palate and/or Tongue Base
         2) Implantable Hypoglossal Nerve Stimulation (HGNS)
         3) Other Surgical Treatments

II. **DEFINITIONS**

III. **REFERENCES**

IV. **REVISION HISTORY**

V. **ATTACHMENTS**
I. COVERAGE

Coverage Statement: The diagnosis and treatment of obstructive sleep apnea are covered when Medicare coverage criteria are met.

DME Face to Face Requirement: Effective July 1, 2013, Section 6407 of the Affordable Care Act (ACA) established a face-to-face encounter requirement for certain items of DME (including respiratory assist devices). For DME Face to Face Requirement information, refer to the Coverage Summary for Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid.

Guidelines/Notes:
1. Diagnosis of obstructive sleep apnea (OSA) is covered. Examples of covered diagnostic services include, but are not limited to:
   a. Oximetry Testing
      - Medicare does not have a National Coverage Determination (NCD) for oximetry testing.
      - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment A).
      - For states with no LCDs/LCAs, see the Palmetto LCD for Respiratory Therapy and Oximetry Services (L33446) for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
      - Committee approval date: September 18, 2018
      - Accessed May 20, 2019
   b. Polysomnography and Sleep Studies
      Effective for claims with dates of service on and after March 3, 2009, the following tests are considered reasonable and necessary:
      1) Type I PSG is covered when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
      2) Type II or Type III sleep testing devices are covered when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
      3) Type IV sleep testing devices measuring three or more channels, one of which is airflow, are covered when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
      4) Sleep testing devices measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone, are covered when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
      - See the NCD for Sleep Testing for Obstructive Sleep Apnea (OSA) (240.4.1). (Accessed September 12, 2018)
      - Local Coverage Determinations exist and compliance with these policies is required where applicable. These LCDs are available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. (Accessed April 1, 2019)
5) **Home Sleep Studies or Polysomnography (G0398, G0399, G0400, 95800, 95801, and 95806)**

- *Medicare does not have a National Coverage Determination (NCD) specifically for home sleep testing or polysomnography.*
- *Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all 50 states and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment D).*
- *Committee approval date: September 18, 2018*
- *Accessed May 20, 2019*

2. Treatment of sleep apnea include, but are not limited to:
   a. **Continuous Positive Airway Pressure (CPAP)**

   Continuous Positive Airway Pressure (CPAP) is a non-invasive technique for providing single levels of air pressure from a flow generator, via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in OSA.

   The use of CPAP is covered when used in adult patients with diagnosis of under the following situations:
   1) The use of CPAP is covered under Medicare when used in adult patients with OSA. Coverage of CPAP is initially limited to a 12-week period to identify beneficiaries diagnosed with OSA as subsequently described who benefit from CPAP. CPAP is subsequently covered only for those beneficiaries diagnosed with OSA who benefit from CPAP during this 12-week period.
   2) The provider of CPAP must conduct education of the beneficiary prior to the use of the CPAP device to ensure that the beneficiary has been educated in the proper use of the device. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate the CPAP device.
   3) A confirmed diagnosis of OSA for the coverage of CPAP must include a clinical evaluation and a positive:
      - attended polysomnography (PSG) performed in a sleep laboratory; or
      - unattended home sleep test (HST) with a Type II home sleep monitoring device; or
      - unattended HST with a Type III home sleep monitoring device; or
      - unattended HST with a Type IV home sleep monitoring device that measures at least 3 channels
   4) The sleep test must have been previously ordered by the beneficiary’s treating physician and furnished under appropriate physician supervision.
   5) An initial 12-week period of CPAP is covered in adult patients with OSA if either of the following criterion using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) are met:
      - AH1 or RDI greater than or equal to 15 events per hour, or
      - AH1 or RDI greater than or equal to 5 events and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

*(Refer to #2.a.1 above for the description and criteria for the initial 12-week trial period for CPAP.)*
6) The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected). If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a two hour period.

7) Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation.

8) **Coverage with Evidence Development (CED)**

Medicare provides limited coverage for CPAP in adult beneficiaries who do not qualify for CPAP coverage based on criteria 1-7 above. A clinical study seeking Medicare payment for CPAP provided to a beneficiary who is an enrolled subject in that study must address one or more of the following questions:

- In Medicare aged subjects with clinically identified risk factors for OSA, how does the diagnostic accuracy of a clinical trial of CPAP compare with PSG and Type II, III & IV HST in identifying subjects with OSA who will respond to CPAP?
- In Medicare aged subjects with clinically identified risk factors for OSA who have not undergone confirmatory testing with PSG or Type II, III & IV HST, does CPAP cause clinically meaningful harm?

The study must meet the additional standards outlined in the NCD for Continuous Positive Airway Pressure CPAP Therapy For Obstructive Sleep Apnea (OSA) (240.4).


*For payment rules for NCDs requiring CED, see the **Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials**.*

See the *NCD for Continuous Positive Airway Pressure CPAP Therapy For Obstructive Sleep Apnea (OSA) (240.4).* (Accessed September 12, 2018)

*Local Coverage Determinations (LCDs) for all states exist and compliance with these LCDs is required where applicable. See the DME MAC LCD for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718). (Accessed May 20, 2019)*

*Also see the DME MAC Positive Airway (PAP) Devices – Supplier Frequently Asked Questions:*


b. **Respiratory Assist Devices including Bilevel Positive Airway Pressure (BiPAP)**

- Medicare does not have a National Coverage Determination (NCD) for respiratory assist devices.
• **Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all 50 states** and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the DME MAC [LCD for Respiratory Assist Devices (L33800)].

• **Committee approval date: September 18, 2018**

• Accessed May 20, 2019

c. **Mandibular Devices/Oral Appliances**

• Medicare does not have a National Coverage Determination (NCD) for mandibular devices/oral appliances for the treatment of OSA.

• **Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all 50 states** and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the DME MAC [LCD for Oral Appliances for OSA (L33611)].

• **Committee approval date: September 18, 2018**

• Accessed May 20, 2019

d. **Electrosleep Therapy**

Until scientific assessment of this technique has been completed and its efficacy is established, no program payment may be made for electrosleep therapy. *see the [NCD for Electrosleep Therapy (30.4)](Accessed September 12, 2018)*

e. **Surgical Treatment**

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

   (CPT code 41530)

   • 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 state-specific LCDs/LCAs, refer to the [LCD Availability Grid (Attachment B)].**

   • **For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Obstructive Sleep Apnea Treatment** for coverage guideline. *(IMPORTANT NOTE: After checking the LCD Availability Grid and searching the [Medicare Coverage Database](#), if no state LCD/LCA is found, then use the above referenced policy.)*

   • **Committee approval date: September 18, 2018**

   • Accessed May 20, 2019

2) **Implantable Hypoglossal Nerve Stimulation (HGNS) [Inspire® Upper Airway Stimulation and the aura6000™ Sleep Therapy System](CPT Codes 64568, 64569, 64570, 0466T, 0467T and 0468T)**

   • Medicare does not have a National Coverage Determination (NCD) for implantable Hypoglossal Nerve Stimulation (HGNS); also known as Inspire Upper Airway Stimulation.

   • **Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the [LCD Availability Grid (Attachment E)].**

   • **For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Obstructive Sleep Apnea Treatment** for coverage guideline. *(IMPORTANT NOTE: After checking the LCD Availability Grid and searching the [Medicare Coverage Database](#), if no state LCD/LCA is found, then use the above referenced policy.)*

   • **Committee approval date: September 18, 2018**

   • Accessed May 20, 2019
3) Other Surgical Treatments

- 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 state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment C).
- For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Obstructive Sleep Apnea Treatment for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- Committee approval date: September 18, 2018
- Accessed May 20, 2019

II. DEFINITIONS

III. REFERENCES

See above

IV. REVISION HISTORY

04/01/2019
- Updated policy introduction; added language to clarify:
  - There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
  - In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5)
- Retitled reference links that direct users to UnitedHealthcare Commercial policies

09/18/2018
- Annual review with the following updates:
  Updated Local Coverage Determination (LCD) Availability Grids; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy).
  Guideline 1.a (Oximetry Testing)
  - Deleted the detailed guideline; same guideline can be accessed in the default Palmetto LCD for Respiratory Therapy and Oximetry Services (L33446).
  - Deleted the specific LCD titles in the statement that LCDs are available.
  Guideline 2.d (Electrosleep Therapy)
  - Moved from Guideline 3 (Examples of services that are not covered)
  - Added “Until scientific assessment of this technique has been completed and its
efficacy is established, no program payment may be made for electrosleep therapy”;
language from the NCD for Electrosleep Therapy (30.4)

Guideline 2.e.2) Implantable Hypoglossal Nerve Stimulation (HGNS)
- Moved from Guideline 3 (Examples of services that are not covered)
- To be consistent with the UnitedHealthCare Medical Policy for Obstructive Sleep Apnea Treatment, added to the title “the aura6000™ Sleep Therapy System” and deleted CPT code 95970.

Guideline 3 (Examples of services that are not covered)
- Deleted “Surgeries or treatments that are dental in nature”; cannot find Medicare manual reference
- Moved “Electrosleep therapy” to Guideline 2.d under Treatment of Sleep Apnea
- Moved “Implantable Hypoglossal Nerve Stimulation (HGNS)” to Guideline 2e under Surgical Treatment of Sleep Apnea

01/16/2018 Re-review with the following updates:

Guideline 1 (Oximetry Testing) – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 1.b.5 [Home Sleep Studies or Polysomnography (G0398, G0399, G0400, 95800, 95801, and 95806)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 3.c [Implantable Hypoglossal Nerve Stimulation (HGNS); also known as Inspire Upper Airway Stimulation (CPT Codes 64568, 64569, 64570, 0466T - 0468T, and 95970)] - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

09/19/2017 Annual review with the following updates:

Guideline 1.a (Oximetry Testing) – removed the following language “(Important Note): After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy.)” as it is a repetitive statement.

Guideline 1.b (Polysomnography and Sleep Studies)
- Removed reference to the following LCDs as they are no longer available: “Sleep Studies” and “Polysomnography and Sleep Studies for Testing Sleep and Respiratory Disorders”
- Added reference to the following LCD: “Medicine: Home Sleep Testing (HST)”

Guideline 1.b.5 [Home Sleep Studies or Polysomnography (G0398, G0399, G0400, 95800, 95801, and 95806)] – new guideline to coverage summary.

Guideline 3.c [Implantable Hypoglossal Nerve Stimulation (HGNS); also known as Inspire Upper Airway Stimulation (CPT Codes 64568, 64569, 64570, 0466T - 0468T, and 95970)]
- Updated title by removing CPT codes 64553, 64999, L8679, L8680, L8686 and adding CPT codes 64568, 0466T - 0468T and 95970 to be consistent with the coding updates effective 01/01/2017.
- Updated language to state LCDs now exist and provided new LCD Availability Grid.
Annual review with the following updates:

Guideline 1 (Diagnosis of obstructive sleep apnea) – deleted the following examples as there are no applicable Medicare reference found: diagnostic X-ray services, routine diagnostic laboratory services, pharyngoscopy, pneumogram for infants 6 months or younger on an outpatient basis, and multiple sleep latency test (MSLT)

Guideline 2 (Continuous Positive Airway Pressure)
- Added the definition of CPAP and Apnea (moved from the Definition section)
- to align with the reference NCD language, deleted “The use of CPAP devices must be ordered and prescribed by the licensed treating physician to be used in adult patients with moderate to severe OSA.”; added- “The sleep test must have been previously ordered by the beneficiary’s treating physician and furnished under appropriate physician supervision.”
- To align with the reference NCD language, updated the language under Coverage with Evidence Development (CED)

Guideline 2.d (Surgical Treatment)
- Added guideline specific to Radiofrequency Submucosal Ablation of the Soft Palate and/or Tongue Base (CPT code 41530)

Definitions
- Moved the following definitions to the applicable guideline section: Apnea, CPAP, and hypopnea
- Deleted the following definitions as there are no applicable Medicare references found: BiPAP, electrosleep study, mandibular devices, and polysomnography.

04/19/2016
Guideline #3.c [Implantable Hypoglossal Nerve Stimulation (HGNS); also known as Inspire Upper Airway Stimulation (CPT Codes 64553, 64568, 64569, 64570, 64999, 95970, L8679-80, L8686)] – Added new guidelines to coverage summary.

03/15/2016
Re-review with updated reference link(s) of the applicable LCDs to reflect the condensed link.

10/20/2015
Annual review with the following updates:
Guideline 1.g (Polysomnography and Sleep Studies) - Updated to include the availability of additional Local Coverage Determinations (LCDs).
Guideline 2.b [Respiratory Assist Devices including Bilevel Positive Airway Pressure (BiPAP)]
- Updated to state that all states now have LCDs
- Detailed guidelines removed and added a reference link to the DME MAC LCDs.
Guideline 2.c [Mandibular Devices/Oral Appliances]
- Detailed guidelines removed and added a reference link to the DME MAC LCDs.

04/21/2015
Guideline #2.a (Continuous Positive Airway Pressure)
- Added reference link to the list of Medicare approved clinical trials.
- Updated payment information; added reference link to the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials for payment rules for NCDs requiring CED.

03/12/2015
Formatting change only.

11/18/2014
Guideline 2.d. Surgical Treatment - Changed default guideline for states with no LCDs from Wisconsin LCD for Surgical Treatment of Obstructive Sleep Apnea (OSA) (L30731)
Definitions

- Updated the definition of:
  - Apnea: added reference link to the DME MAC Local Coverage Determination (LCD) for Oral Appliances for Obstructive Sleep Apnea
  - Bilevel Positive Airway Pressure (BiPAP): added reference link to the DME MAC Local Coverage Determinations (LCDs) for Respiratory Assist Devices
  - Continuous Positive Airway Pressure (CPAP): added reference link to the DME MAC Local Coverage Determinations (LCDs) for Respiratory Assist Devices.
  - Electrosleep Therapy: added reference link to the NCD for Electrosleep Therapy (30.4)
  - Hypopnea: added reference link to the DME MAC Local Coverage Determination (LCD) for Oral Appliances for Obstructive Sleep Apnea
  - Mandibular Devices: added reference link to the DME MAC Local Coverage Determination (LCD) for Oral Appliances for Obstructive Sleep Apnea
  - Polysomnography: added reference link to the NCD for Sleep Testing for Obstructive Sleep Apnea (OSA) (240.4.1)
- Removed the definition of:
  - Snoreplasty (not used within this coverage summary)

10/21/2014 Removed detailed DME Face-to-Face Requirement information and replaced with a reference link to the DME, Prosthetics, Corrective Appliances/Orthotic and Medical Supplies Grid.

04/15/2014 Guideline #2.a (Continuous Positive Airway Pressure) – added LCD Availability Grid for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea.

10/24/2013 Annual review, no updates.

08/20/2013 Added a note pertaining to the DME Face-to-Face Requirement in accordance with Section 6407 of the Affordable Care Act as defined in the 42 CFR 410.38(g).

10/31/2012 Annual review with the following updates:
- Guidelines #1.f (Oximetry Testing) updated to include additional information pertaining to documentation requirement for Continuous Overnight Oximetry (94762).
- Guidelines #2.d (Surgical Treatment) updated to state that there is only one contractor with LCDs for Surgical Treatment of OSA.

09/06/2012 Guidelines #2.a Continuous Positive Airway Pressure updated to include the reference and links to the DME MAC Positive Airway (PAP) Devices – Supplier Frequently Asked Questions.

10/13/2011 Annual review with the following updates:
- Guidelines #1.f (Oximetry Testing) updated, i.e., changing the basis for default guidelines for states with no LCDs from CIGNA LCD, L6465 to Palmetto LCD, L31755.
- Guidelines #2.c (Mandibular Devices/Oral Appliances) updated, i.e., deleting the default guidelines based on LCDs (Noridian L19078 & L24373) for states with no LCDs and adding the coverage guidelines for all states based on the 4 DME MAC LCDs for Oral Appliances for OSA.
- Guidelines #2.d (Surgical Treatment) updated, i.e., changing the basis for default
Updated Guidelines #2.b - Bilevel Positive Airway Pressure (BiPAP) and other Respiratory Assist Devices to include the note pertaining to the new CMS instruction on the Elimination of Least Costly Alternative Language (effective February 4, 2011).

11/16/2010  Title changed from “Obstructive Sleep Apnea” to “Sleep Apnea – Diagnosis and Treatment”.
Updated the following: Guidelines #1.g Polysomnography and Sleep Studies, Guidelines #2.b Bilevel Positive Airway Pressure (BiPAP) and other Respiratory Assist Devices, Guidelines #2.c Mandibular Devices/Oral Appliances and Guidelines #2.d Surgical Treatment.
Deleted the following: Guidelines #3.a Sleep therapy/hypnosis (no CMS reference), Guidelines #3.c LAUP (now addressed in #2.d), #3.d Somnoplasty (now addressed in #2.d) and #3.e Mandibular Devices (now addressed in #2.c) and #3.g Snoreplasty (no CMS reference).

V. ATTACHMENT(S)

Attachment A - LCD Availability Grid
Oximetry Services (Pulse Oximetry)

<table>
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<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
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<th>States</th>
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<tbody>
<tr>
<td>L33446</td>
<td>Respiratory Therapy and Oximetry Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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<td>L35434</td>
<td>Oximetry Services</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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End of Attachment A

Attachment B - LCD Availability Grid
Radiofrequency Submucosal Ablation of the Soft Palate and/or Tongue Base
(CPT code 41530)

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<tr>
<td>L34526</td>
<td>Surgical Treatment of Obstructive Sleep Apnea (OSA)</td>
<td>MAC Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SD, TN, UT, VA, VI, VT, WA, WI, WV, WY</td>
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<tr>
<td>L34526</td>
<td>Surgical Treatment of Obstructive Sleep Apnea (OSA)</td>
<td>MAC Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MS, NE</td>
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<td>L33777</td>
<td>Noncovered Services</td>
<td>MAC Part A and B</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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<td>L36954</td>
<td>Noncovered Services other than CPT® Category III Noncovered Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV AL, GA, TN</td>
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End of Attachment B
## Attachment C - LCD Availability Grid
### Other Surgical Treatments of Obstructive Sleep Apnea (OSA)
(CMS website accessed May 20, 2019)

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<th>Contractor</th>
<th>States</th>
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<tr>
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<td>MAC Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
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<tr>
<td>L34526</td>
<td>Surgical Treatment of Obstructive Sleep Apnea (OSA)</td>
<td>MAC Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MS, NE</td>
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End of Attachment C

## Attachment D - LCD Availability Grid
### Home Sleep Studies or Polysomnography
(CPT codes G0398, G0399, G0400, 95800, 95801, and 95806)
(CMS website accessed May 20, 2019)

<table>
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<th>LCD ID</th>
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<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
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<td>L35050</td>
<td>Outpatient Sleep Studies</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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<td>L36902</td>
<td>Polysomnography and Other Sleep Studies</td>
<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
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End of Attachment D

## Attachment E - LCD Availability Grid
### Implantable Hypoglossal Nerve Stimulation (HGNS)
(CPT codes 64568, 64569, 64570, 0466T, 0467T and 0468T)
(CMS website accessed May 20, 2019)

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End of Attachment E