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: 09/17/2019

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)

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource 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. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

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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III. REFERENCES

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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 17, 2019
      - Accessed December 16, 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.
      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.
      - See the NCD for Sleep Testing for Obstructive Sleep Apnea (OSA) (240.4.1). (Accessed September 5, 2019)
      - 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 September 5, 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 17, 2019**
   - **Accessed December 16, 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:
      - AHI or RDI greater than or equal to 15 events per hour, or
      - AHI 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 Guideline 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.


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 December 16, 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 17, 2019**
  • **Accessed December 16, 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 17, 2019**
  • **Accessed December 16, 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 5, 2019)

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 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 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 17, 2019**
  • **Accessed December 16, 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 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 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*
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 17, 2019
- Accessed December 16, 2019

II. DEFINITIONS

III. REFERENCES

See above

IV. REVISION HISTORY

09/17/2019
- Routine review; no change to coverage guidelines

Attachments
- Updated Local Coverage Determination (LCD) Availability Grids to reflect the most current reference links

V. ATTACHMENT(S)

Attachment A - LCD Availability Grid

Oximetry Services (Pulse Oximetry)

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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<tr>
<td>L33446</td>
<td>Respiratory Therapy and Oximetry Services</td>
<td>A and B MAC</td>
<td>Palmetto GB</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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<th>LCD ID</th>
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<td>L34526</td>
<td>Surgical Treatment of Obstructive Sleep Apnea (OSA)</td>
<td>MAC Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
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End of Attachment B
### Attachment B - LCD Availability Grid

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

(CPT code 41530)

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<tr>
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<tr>
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<td>MAC Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
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<tr>
<td>L33777 (A57743)</td>
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<td>FL, PR, VI</td>
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<td>L36954 (A56506)</td>
<td>Non-covered 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)

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<td>MAC Part A</td>
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<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)

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<tr>
<td>L35050 (A56923)</td>
<td>Outpatient Sleep Studies</td>
<td>A and B MAC</td>
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<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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<tr>
<td>L36902</td>
<td>Polysomnography and Other Sleep Studies</td>
<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
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<tr>
<td>L34040 (A57698)</td>
<td>Polysomnography and Other Sleep Studies</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
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<tr>
<td>L36861 (A57697)</td>
<td>Polysomnography and Other Sleep Studies</td>
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<td>L36839 (A56903)</td>
<td>Polysomnography and Other Sleep Studies</td>
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<td>L33405 (A57496)</td>
<td>Polysomnography and Sleep Testing</td>
<td>MAC Part A and B</td>
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### Attachment D - LCD Availability Grid

**Home Sleep Studies or Polysomnography**
(CPT codes G0398, G0399, G0400, 95800, 95801, and 95806)

CMS website accessed December 16, 2019

<table>
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<tr>
<th>LCD ID</th>
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<td>Non-Covered Category III CPT Codes</td>
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<td>L33392 (A56195)</td>
<td>Category III CPT® Codes</td>
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<td>National Government Services, Inc.</td>
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<tr>
<td>L35094 (A56967)</td>
<td>Services That Are Not Reasonable and Necessary</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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</table>

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 December 16, 2019

<table>
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<tr>
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End of Attachment E