Coverage Summary

Sleep Apnea: Diagnosis and Treatment

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 09/19/2017

Related Medicare Advantage Policy Guidelines:
- Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) and Other Respiratory Assist Devices (RAD) (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.

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**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) exist and compliance with these LCDs is required where applicable. For state-specific LCDs, refer to the LCD Availability Grid (Attachment A).
      - For states with no LCDs, refer to the following Coverage Summary guidelines below; based on Palmetto LCD for Respiratory Therapy and Oximetry Services (L33446).
      - Committee approval date: September 19, 2017
      - Accessed August 23, 2017

   **IMPORTANT NOTE:** After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the Coverage Summary guidelines below.)

   **Coverage Summary Guidelines for state with no LCDs:**
   Medically necessary reasons for pulse oximetry include:
   - Patient exhibits signs or symptoms of acute respiratory dysfunction such as:
     o Tachypnea
     o Dyspnea
     o Cyanosis
     o Respiratory distress
     o Confusion
     o Hypoxia
   - Patient has chronic lung disease, severe cardiopulmonary disease, or neuromuscular disease involving the muscles of respiration, and oximetry is needed for at least one of the following reasons:
     o Initial evaluation to determine the severity of respiratory impairment.
     o Evaluation of an acute change in condition.
     o Evaluation of exercise tolerance in a patient with respiratory disease.
     o Evaluation to establish medical necessity of oxygen therapeutic regimen.
   - Patient has sustained severe multiple trauma or complains of acute severe chest pain.
   - Patient is under treatment with a medication with known pulmonary toxicity, and oximetry is medically necessary to monitor for potential adverse effects of therapy.

   **Note:** Codes 94760 and 94761 are bundled by the Correct Coding Initiative (CCI) with critical care services. Therefore, codes 94760 and 94761 cannot be paid separately when billed with critical care (codes 99291 and 99292).
CPT code 94762 is considered medically necessary when performed for any of the following reasons:

- The patient has a condition for which intermittent arterial blood gas sampling is likely to miss important variations.
- The patient has a condition resulting in hypoxemia and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen.

For Continuous Overnight Oximetry (94762), the patient's record must document that the oximeter is preset and self-sealed and cannot be adjusted by the patient. In addition, the device must provide a printout that documents an adequate number of sampling hours, percent of oxygen saturation and an aggregate of the results. This information must be available if requested. In all instances, there must be a request documented in the medical record from the treating physician for these services.

The results of tests performed by a durable medical equipment supplier or his employees to qualify patients for home oxygen service are not covered.

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 15, 2017)

- Local Coverage Determinations exist and compliance with these policies is required where applicable. See the following LCDs at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx (Accessed September 15, 2017)
  - Polysomnography
  - Polysomnography and Other Sleep Studies
  - Polysomnography and Sleep Testing
  - Outpatient Sleep Studies
  - Medicine: Home Sleep Testing (HST)

5) Home Sleep Studies or Polysomnography (G0398, G0399, G0400, 95800, 95801,
2. Treatment of sleep apnea; examples 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 #2.a.1 above for the description and criteria for the initial 12-week trial*
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 15, 2017)*

*Local Coverage Determinations(LCDs) for all states exist and compliance with these LCDs is required where applicable. See the DME MAC LCDs for LCD for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718).** *(Accessed September 15, 2017)*

*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) for all states exist and compliance with these LCDs is required where applicable.
   • For coverage guidelines, refer to the DME MAC LCD for Respiratory Assist Devices (L33800).
   • Committee approval date: September 19, 2017
   • Accessed August 23, 2017

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) for all states exist and compliance with these LCDs is required where applicable.
   • For coverage guidelines, refer to the DME MAC LCD for Oral Appliances for OSA (L33611).
   • Committee approval date: September 19, 2017
   • Accessed August 23, 2017

d. 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) exist and compliance with these LCDs is required where applicable. Refer to the LCD Availability Grid (Attachment B).
      • For states with no LCDs, refer to the UnitedHealthcare Medical Policy for Obstructive Sleep Apnea Treatment for coverage guidelines. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy.)
      • Committee approval date: September 19, 2017
      • Accessed August 23, 2017
   2) Other Surgical Treatments
      • Medicare does not have a National Coverage Determination (NCD) for other surgical treatments of OSA.
      • Local Coverage Determinations (LCDs) exist and compliance with these LCDs is required where applicable. Refer to the LCD Availability Grid (Attachment C).
      • For states with no LCDs, refer to the UnitedHealthcare Medical Policy for Obstructive Sleep Apnea Treatment UnitedHealthcare Medical Policy for Obstructive Sleep Apnea Treatment for coverage guidelines. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy.)
      • Committee approval date: September 19, 2017
      • Accessed August 23, 2017

3. The following examples of services that are not covered, but are not limited to:
a. Surgeries or treatments that are dental in nature; refer to the Coverage Summary for Dental Services, Oral Surgery and Treatment of Temporomandibular Joint (TMJ).

b. Electrosleep therapy; see the NCD for Electrosleep Therapy (30.4). (Accessed August 23, 2017)

c. Implantable Hypoglossal Nerve Stimulation (HGNS); also known as Inspire Upper Airway Stimulation (CPT Codes 64568, 64569, 64570, 0466T - 0468T, and 95970)
   - Medicare does not have a National Coverage Determination (NCD) for hypoglossal nerve stimulation for sleep apnea.
   - Local Coverage Determinations (LCDs) specifically for implantable hypoglossal nerve stimulation exist and compliance with these LCDs is required where applicable. Refer to the LCD Availability Grid (Attachment E).
   - For coverage guidelines, refer to the UnitedHealthcare Medical Policy for Obstructive Sleep Apnea Treatment for coverage guidelines. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD or Local Article is found, then use the above referenced policy.)
   - Committee approval date: September 19, 2017
   - Accessed August 23, 2017

II. DEFINITIONS

III. REFERENCES

See above

IV. REVISION HISTORY

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 2a (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 2d (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.

Guideline #3c [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.

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

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.

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.

Formatting change only.

Guideline 2.d. Surgical Treatment - Changed default guideline for states with no
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 guidelines for states with no LCDs from Noridian LCDs, L19078 & L24373 and Palmetto LCD, L28307 to Wisconsin LCD, L30731.

02/21/2011 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)**

CMS website accessed September 15, 2017

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<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 GBA</td>
<td>NC, SC, 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**

CMS website accessed September 15, 2017

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<th>Contractor Type</th>
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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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<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>
</tr>
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</table>
### Attachment B - LCD Availability Grid

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

CMS website accessed September 15, 2017

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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<th>LCD ID</th>
<th>LCD Title</th>
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<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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**End of Attachment B**

### Attachment C - LCD Availability Grid

**Other Surgical Treatments of Obstructive Sleep Apnea (OSA)**

CMS website accessed September 15, 2017

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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<th>LCD ID</th>
<th>LCD Title</th>
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<td>L34526</td>
<td>Surgical Treatment of Obstructive Sleep Apnea (OSA)</td>
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**End of Attachment C**

### Attachment D - LCD Availability Grid

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

CMS website accessed August 23, 2017

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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<td>Outpatient Sleep Studies</td>
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<td>Novitas Solutions, Inc.</td>
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<td>L36902</td>
<td>Polysomnography and Other Sleep Studies</td>
<td>A and B MAC</td>
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<td>L34040</td>
<td>Polysomnography and Other Sleep Studies</td>
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<td>Polysomnography and Sleep Testing</td>
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<td>A53019</td>
<td>Polysomnography and Sleep Studies – Medical Policy Article</td>
<td>MAC Part A and B</td>
<td>National Government Services, Inc.</td>
<td>NY-ENTIRE STATE, MA, ME, NH, RH, VT</td>
</tr>
</tbody>
</table>

**End of Attachment D**
# Attachment E - LCD Availability Grid

**Implantable Hypoglossal Nerve Stimulation (HGNS); also known as Inspire Upper Airway Stimulation (CPT Codes 64568, 64569, 64570, 0466T - 0468T, and 95970)**

CMS website accessed September 15, 2017

IMPORTANT NOTE: Use the applicable LCD based on member’s residence/place of service AND type of service.

<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>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>L36219</td>
<td>Non Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>CA-ENTIRE STATE, AS, GU, HI, MP, NV</td>
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<td>L34555</td>
<td>Non-Covered Category III CPT Codes</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV</td>
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<td>L33392</td>
<td>Category III CPT® Codes</td>
<td>MAC Part A and B</td>
<td>National Government Services, Inc.</td>
<td>NY-ENTIRE STATE, MA, ME, NH, RH, VT</td>
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<td>Non-Covered Services</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
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<tr>
<td>L35094</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>
</tr>
</tbody>
</table>

End of Attachment E