

**Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401,  
05102, 05202, 05302, 05402, 52280

**Contractor Type**

Carrier B  
Fiscal Intermediary A  
MAC A  
MAC B

**LCD Database ID Number**

**LCD Version Number**

**LCD Title**

Surgical Treatment of Obstructive Sleep Apnea (OSA)

**Contractor's Determination Number**

ENT-012

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**CMS National Coverage Policy**

CMS Pub. 100-3 Medicare National Coverage Determinations Manual:

Ch.1 §240.4 Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA) (

CMS Pub. 100-02 Medicare Benefit Policy Manual

Ch.15 §70- Sleep Disorder Clinics

Ch.16 §140 Dental Services Exclusion

1862 (a)(1)(A) Medically Reasonable & Necessary.

1862 (a)(1)(D) Investigational or Experimental.

**Primary Geographic Jurisdiction**

**Carrier B:** Wisconsin, Illinois, Michigan, Minnesota

**Fiscal Intermediary A:** Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands

**MAC A/B:** Iowa, Missouri, Nebraska, Kansas

## **Oversight Region**

## **Original Determination Effective Date**

## **Revision Effective Date**

### **Indications and Limitations of Coverage and/or Medical Necessity**

Sleep-Disordered Breathing, often referred to as Obstructive Sleep Apnea (OSA), is characterized by frequent episodes of hypopnea or apnea during sleep. Multiple detrimental physiologic changes may result from these hypopneic and apneic episodes. Non-surgical and surgical approaches to obstructive apnea and hypopnea have been developed.

Continuous Positive Airway Pressure (CPAP) breathing is the treatment of choice for OSA. Some patients do not tolerate CPAP, or are not benefited from it. The level of obstruction in OSA (retropalatal, retrolingual, and retropalatal and retrolingual) is variable.

Uvulopalatopharyngoplasty (UPPP) is an accepted means of surgical treatment for this disorder, but is curative in less than 50% of patients. Scientific evidence suggests that UPPP is useful in retropalatal and combination retropalatal and retrolingual obstruction.

Mandibular Maxillary Osteotomy and Advancement is a procedure developed for those patients with retrolingual obstruction, or those patients with retropalatal and retrolingual obstruction who have not responded to CPAP and uvulopalatopharyngoplasty. Medical data on the efficacy of this treatment has been reported from only a small number of centers, but the information appears to show good results for those patients who meet certain criteria. It is unknown whether the technique will result in similar results outside specialized centers.

Tracheostomy remains the surgical approach with the greatest effectiveness since it bypasses all areas of obstruction in the nasal, palatal, lingual, and pharyngeal areas. However, tracheostomy is associated with significant morbidity, and is usually reserved for patients who have failed other medical or surgical methods of treatment, or who are unsuitable for other methods of treatment for various reasons.

Various other anatomic abnormalities (such as, but not limited to, enlarged tonsils or tongue) sometimes cause OSA also. Surgical approaches to these abnormalities will vary according to the anatomic defect and the procedure/procedures needed to correct the defined problem.

Genioglossal advancement, with or without resuspension of the hyoid bone, may be performed with uvulopalatopharyngoplasty, but this procedure is not always successful, and there is little definitive information on its benefit.

- A. Uvulopalatopharyngoplasty (UPPP) is covered for those patients who have **all** of the following:
1. Obstructive sleep apnea diagnosed (prior to any proposed surgery) in a certified sleep disorders laboratory (certification body recognized by the American Academy of Sleep Medicine);
  2. A Respiratory Disturbance Index of 15 or higher
  3. Failed to respond to Continuous Positive Airway Pressure therapy or cannot tolerate CPAP or other appropriate non-invasive treatment;
  4. Documented counseling by a physician, with recognized training in sleep disorders, about the potential benefits and risks of the surgery; **and**
  5. Evidence of retropalatal or combination retropalatal/retrolingual obstruction as the cause of the obstructive sleep apnea.
- B. Mandibular Maxillary Osteotomy and Advancement and /or genioglossus advancement with or without hyoid suspension is covered for those patients who have all of the following:
1. Obstructive sleep apnea diagnosed (prior to any proposed surgery) in a certified sleep disorders laboratory (certification body recognized by the American Academy of Sleep Medicine);
  2. A Respiratory Disturbance Index of 15 or higher;
  3. Failed to respond to Continuous Positive Airway Pressure therapy or cannot tolerate CPAP or other appropriate non-invasive treatment;
  4. Documented counseling by a physician, with recognized training in sleep disorders, about the potential benefits and risks of the surgery; **and**
  5. Evidence of retrolingual obstruction as the cause of the obstructive sleep apnea, or previous failure of UPPP to correct the obstructive sleep apnea.  
Regarding the Mandibular Maxillary Osteotomy and Advancement operation:
    - a. Separate repositioning of teeth would not be necessary except under unusual circumstances; but if necessary the dental work would be covered.
    - b. Application of an interdental fixation device is occasionally necessary, and is a covered service (see Documentation Requirements).
- C. Tracheostomy is covered for obstructive sleep apnea that is in the judgment of the attending physician, unresponsive to other means of treatment or in cases where other means of treatment would be ineffective or not indicated.
- D. When obstructive sleep apnea is caused by discrete anatomic abnormalities of the upper airway (such as, but not limited to, enlarged tonsils or an enlarged tongue), surgery to correct these abnormalities is covered if medically necessary based on adequate documentation in the medical records supporting the significant contribution of these abnormalities to OSA. Submucous radiofrequency reduction of hypertrophied turbinates is covered as an appropriate treatment for nasal obstruction due to turbinate hypertrophy that significantly contributes to OSA or significantly compromises CPAP therapy. .

E. The following procedures are not covered at this time.

1. Laser-assisted uvulopalatoplasty (LAUP) is not covered at this time since it is not considered effective for OSA. LAUP **must not** be billed as 42145, Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty). This code is not appropriate for this procedure. If LAUP is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "LAUP" listed in Item 19 on the CMS-1500 claim form or equivalent field for electronic claims. The claim will then be appropriately denied as not proven effective.

2. Somnoplasty™ is a trade name for palate reduction with the Somnoplasty™ System of Somnus Medical Systems. This is not a term recognized by this Contractor as a covered procedure under Medicare Part B. Therefore Somnoplasty™ must not be billed as 42145. This code is not appropriate for this procedure. If Somnoplasty™ is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "Somnoplasty™" listed in Item 19 on the CMS-1500 claim form or equivalent field for electronic claims. This claim will then be appropriately denied as not proven effective.

3. The Pillar Procedure™ is a trade name for palatal implants. Palatal implants have not been shown effective for the treatment of obstructive sleep apnea and are not covered. This procedure should be billed by the physician as 42299 (unlisted procedure, palate, uvula) with "Pillar Procedure™" or "palatal implant" listed in Item 19 on the CMS- 1500 claim form or equivalent field for electronic claims. This claim will then be denied as not proven effective. Hospital outpatient would use code C9727 .

4. Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session. (41530) is not covered.

### **Bill Type Codes**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

### **Revenue Codes**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

### **CPT/HCPCS Codes**

21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, 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 fixation
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21685	Hyoid myotomy and suspension
30802	Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; Intramural
30140	Submucous resection inferior turbinate, partial Or complete, any method
31600	Tracheostomy, planned (separate procedure)
31610	Tracheostomy, fenestration procedure with skin Flaps
41512	Tongue base suspension, permanent suture technique
41530	Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
C9727	Insertion of implants into the soft palate; minimum of three implants
42299	Unlisted procedure of the palate

## **Does the CPT 30% Rule Apply**

No

## **ICD-9 Codes that Support Medical Necessity**

Note: ICD-9 codes must be coded to the highest level of specificity.

These are the **only** covered diagnoses for CPT codes **21685, and 42145**. This list will not address the other listed HCPCS services/procedures.

327.23	Obstructive sleep apnea (adult) (pediatric)
780.51	Insomnia with sleep apnea, unspecified
780.53	Hypersomnia with sleep apnea, unspecified
780.57	Unspecified sleep apnea

These are the **only** covered diagnoses for CPT code **41512, 41530**:

**\*Both** the primary ICD-9-CM code 327.23 (Obstructive sleep apnea) and at least one of the following secondary codes (529.8 or 750.15) must be present on the claim.

### **Primary diagnosis code for CPT codes 41512, 41530:**

327.23 OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)

### **Secondary diagnosis code for CPT codes 41512, 41530:**

529.8 OTHER SPECIFIED CONDITIONS OF THE TONGUE

750.15 MACROGLOSSIA

Note that ICD-9-CM code 529.8 may be used only for tongue hypertrophy. Each of the conditions must be documented in the medical record which must be made available to Medicare on request.

## **Diagnoses that Support Medical Necessity**

### **ICD-9 Codes that DO NOT Support Medical Necessity**

### **Diagnoses that DO NOT Support Medical Necessity**

### **Documentation Requirements**

Physicians' Services and diagnostic tests/x-rays must be submitted with an ICD-9 code to support medical necessity and must be coded to the greatest level of specificity and the highest level of digit completeness. The precise ICD-9 code that most fully explains the narrative diagnosis contained in the medical record or test interpretation/report including the 4th or 5th digit sub-classification for the diagnosis category is expected. The ICD-9 code based on the results of the test should be the primary diagnosis. If the test results are normal or inconclusive the ICD-9 code representing the sign, symptom, illness or injury prompting the ordering of the test/x-ray should be reported as the primary diagnosis. In the absence of signs, symptoms, illness or injury, a screening ICD-9 code should be reported, and payment will be denied.

The patient's medical records must be legible, contain the relevant history, and physical findings conforming to the criteria listed under the "Indications and Limitations of Coverage and/or Medical Necessity" section, and must be made available to the contractor upon request.

Documentation of the counseling of the risks and benefits of the procedure must be included in the patient's medical records and must be made available to the Contractor on request.

Documentation of adequate trial of CPAP or other modes of continuous positive airway pressure therapy for obstructive sleep apnea under the care of a physician specifically trained in sleep disordered breathing must also be included in the patient's medical record and must be made available to the Contractor on request. Absence of this information could result in denial.

After adequate healing of the surgical site, follow-up evaluation by a physician with recognized training in sleep disorders is recommended and shall be documented accordingly.

### **Utilization Guidelines**

#### **Sources of Information and Basis for Decision**

Davila, D. G., 1995, "Medical Considerations in Surgery for Sleep Apnea", *Oral and Maxillofacial Surgery Clinics of North America*, 7: 205-221.

Finkelstein, Y., et al, 1997 Uvulopalatopharyngoplasty Vs Laser-Assisted Uvulopalatoplasty, *Arch Otolaryngol, Head Neck Surgery*, Vol. 123, March 1997 pg. 265-276.

Riley, R.W., et al, 1993, "Obstructive Sleep Apnea Syndrome: A Review of 306 Consecutively Treated Surgical Patients", *Otolaryngol Head Neck Surg*, 108: 117-125.

Sher, A.E., et al, 1996, "The Efficacy of Surgical Modifications of the Upper Airway in Adults with Obstructive Sleep Apnea Syndrome", *Sleep*, 19: 156-177.

Standards of Practice Committee of the American Sleep Disorders Association, "Practice Parameters for the Treatment of Obstructive Sleep Apnea in Adults: the Efficacy of Surgical Modifications of the Upper Airway", *Sleep*, 1996; 19: 152-155.

Strollo, P.J., and Rogers, R.M., 1994, "Obstructive Sleep Apnea", *New Engl J. Med.*, 334: 99-104.

National Institutes of Health, National Heart, Lung, and Blood Institute: Treatment of Sleep Disorders (1997)

Carrier Medical Directors' New Technology Work Group.  
Consultants in Otolaryngology and Oro-Mandibular Surgery.

Standards of Practice Committee, American Academy of Sleep Medicine, "Practice Parameters for the Use of Laser-Assisted Uvulopalatoplasty: An Update for 2000", *Sleep*, 24: 603-619.

Friedman M. et al, 2006, "Patient Selection and Efficacy of Pillar Implant Technique for the Treatment of Snoring and Obstructive Sleep Apnea/Hypopnea Syndrome", *Otolaryngol Head and Neck Surg*.2006 Feb;134(2):187-196

Nordgard S. et al, 2006 "Soft Palate Implants for the Treatment of Mild to Moderate Obstructive Sleep Apnea", *Otolaryngol Head and Neck Surg*.2006 Apr;134(4):565-570

#### **Advisory Committee Meeting Notes**

Meeting Date:

Wisconsin:	2/12/2010
Illinois:	1/13/2010

Michigan:	1/27/2010
Minnesota:	1/14/2010
J-5 MAC (IA,KS, MO, NE)	2/19/2010

**Open LCD meeting**

01/06/2010

**Start Date of Comment Period**

2/19/2010

**End Date of Comment Period**

4/5/2010

**Start Date of Notice Period**

(Published)

**Revision History Number/Explanation**

**Last Reviewed On**

**Related Documents**

**LCD Attachments**

**Notes**

\*- An asterisk indicates a revision to that section of the policy.

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the MAC contractor this policy was developed in cooperation with advisory groups which include representatives from various specialties, and adapted for the purpose of converting to MAC jurisdiction.

**Does this LCD contain a "Least Costly Alternative" Provision?**

No