Clinical Policy: Sleep Apnea Diagnosis and Treatment
Reference Number: WA.CP.MP.523
Last Review Date: 12/19

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the medical necessity guidelines for sleep apnea diagnosis and treatment. 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. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

CPAP is considered the first line standard of treatment for sleep apnea and should be the first choice for sleep physicians for adult clients with sleep-disordered breathing and daytime sleepiness with mild to moderate obstructive sleep apnea. Sleep physicians should consider oral appliances rather than no treatment for adults intolerant of CPAP or for whom CPAP is contraindicated.

Surgical treatment of OSA may be needed if CPAP and oral appliances are not tolerated or contraindicated.

The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

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.

Policy/Criteria
I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that a diagnosis of OSA can be made with results from any of the following sleep tests:
   A. Attended polysomnography (PSG) performed in a sleep laboratory
   B. Unattended home sleep test (HST) with a Type II home sleep monitoring device;
   C. Unattended HST with a Type III home sleep monitoring device;
   D. Unattended HST with a Type IV home sleep monitoring device that measures at least 3 channels

II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority’s Health Technology Assessment, that initial CPAP therapy is considered medically necessary when all the following criteria are met:
   A. Member is 18 years of age or older.
B. Member has been diagnosed with OSA via a clinical evaluation and a positive sleep study which documents one of the following:
   1. AHI or RDI greater than or equal to 15 events per hour, or
   2. AHI or RDI greater than or equal to 5 events and less than or equal to 14 events per hour with documented symptoms of one of the following
      a. Excessive daytime sleepiness,
      b. Impaired cognition,
      c. Mood disorders,
      d. Insomnia, or
      e. Documented hypertension, ischemic heart disease or history of stroke.

C. For purchase of CPAP following rental period, Coordinated Care of Washington, Inc. utilizes McKesson InterQual criteria to determine medical necessity.

III. It is the policy Coordinated Care of Washington, Inc., that custom-made mandibular advancement device (MAD) is considered medically necessary as defined in Clinical Policy WA.CP.MP.500 – Mandibular Advancement Devices.

IV. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority, that surgical treatment of OSA is considered medically necessary when the following criteria have all been met:
   A. OSA diagnosed in a certified sleep disorders laboratory,
   B. An RDI of 15 or higher
   C. Failure to respond to CPAP or cannot tolerate CPAP or other appropriate non-invasive treatment such as MAD.
   D. Documented counseling by a physician with recognized training in sleep disorders, about the potential benefits and risks of the surgery,
   E. Additional procedure-specific criteria must be met:
      1. Uvulopalatopharyngoplasty (UPPP) – evidence of retropalatal or combination retropalatal/retrolingual obstruction as the cause of the obstructive sleep apnea.
      2. Mandibular maxillary osteotomy and advancement and/or genioglossus advancement with or without hyoid suspension – evidence of retrolingual obstruction as the cause of the OSA or previous failure of UPPP to correct the OSA.
      3. Tracheostomy – when in the judgment of the attending physician OSA is unresponsive to other means of treatments or other means of treatment would be ineffective or not indicated.
      4. Surgery to correct discrete anatomic abnormalities of the upper airway (such as enlarged tonsils or an enlarged tongue) – adequate documentation in the medical records supporting significant contribution of these abnormalities to OSA.
      5. Submucous radiofrequency reduction of hypertrophied turbinates – evidence that obstruction due to turbinate hypertrophy significantly contributes to OSA or significantly compromises CPAP therapy.

V. It is the policy of Coordinated Care of Washington, Inc., that implantable hypoglossal nerve stimulation is considered medically necessary as defined in Clinical Policy CP.MP.180 – Implantable Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea.
Background
This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>21193</td>
<td>Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy, without bone graft</td>
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<tr>
<td>21194</td>
<td>Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy, with bone graft</td>
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<tr>
<td>21195</td>
<td>Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation</td>
</tr>
<tr>
<td>21196</td>
<td>Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation</td>
</tr>
<tr>
<td>21198</td>
<td>Osteotomy, mandible, segmental</td>
</tr>
<tr>
<td>21199</td>
<td>Osteotomy, mandible, segmental; with genioglossus advancement</td>
</tr>
<tr>
<td>21206</td>
<td>Osteotomy, maxilla, segmental</td>
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<tr>
<td>21685</td>
<td>Hyoid myotomy and suspension</td>
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<tr>
<td>42145</td>
<td>Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)</td>
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<tr>
<td>95806</td>
<td>Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort</td>
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<tr>
<td>95800</td>
<td>Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory analysis and sleep time</td>
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<tr>
<td>95801</td>
<td>Sleep study, unattended, simultaneous recording of minimum of heart rate, oxygen saturation, respiratory analysis.</td>
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<tr>
<td>95807</td>
<td>Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate and oxygen saturation, attended by a technologist</td>
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<td>95808</td>
<td>Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist</td>
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<tr>
<td>95810</td>
<td>Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist</td>
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<tr>
<td>95811</td>
<td>Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of CPAP or BiPAP, attended by a technologist</td>
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<tr>
<td>95782</td>
<td>Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist</td>
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CPT® Codes | Description
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95783 | Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of CPAP or BiPAP, attended by a technologist

HCPCS Codes | Description
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A7027 | Combination oral/nasal mask used with positive airway pressure device
A7030 | Full face mask used with positive airway pressure device
A7031 | Face mask interface, replacement for full face mask
A7033 | Nasal pillow, replacement
A7034 | Nasal mask used with positive airway pressure device
A7035 | Headgear used with positive airway pressure device
A7036 | Chin strap used with positive airway pressure device
A7037 | Tubing used with positive airway pressure device
A7038 | Disposable filter used with positive airway pressure device
A7039 | Non-disposable filter used with positive airway pressure device
A7044 | Oral interface used with positive airway pressure device
E0601 | CPAP Device
E0470 | BiPAP without back-up rate feature
E0471 | BiPAP with back-up rate feature, used with noninvasive interface
E0472 | BiPAP with back-up rate feature, used with invasive interface (tracheostomy)
E0561 | Humidifier, nonheated, used with positive airway pressure device
E0562 | Humidifier, heated, used with positive airway pressure device

Reviews, Revisions, and Approvals

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<th>Policy developed.</th>
<th>Date</th>
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<td>10/19</td>
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<tr>
<td>Reference to CP.MP.180 added</td>
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<td>01/20</td>
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References
4. Wisconsin Physicians Service Insurance Corporation. Surgical Treatment of Obstructive Sleep Apnea (OSA). Local Coverage Determination L34526, for services performed on or
Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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members and/or submitting claims for payment for such services.

**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the
coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence.
Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical
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