

Obstructive Sleep Apnea and Other Sleep Related Breathing Disorders Surgical Treatments



INDEPENDENT CARE HEALTH PLAN

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Medicare Advantage Medical Coverage Policy

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Disclaimer

The Coverage Summaries are reviewed by the iCare Medicare Utilization Management Committee. Clinical policy is not intended to preempt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another. Clinical technology is constantly evolving, and we reserve the right to review and update this policy periodically. References to CPT® codes or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee of claims payment. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any shape or form or by any means, electronic, mechanical, photocopying or otherwise, without permission from iCare.

Related Medicare Advantage Medical/Pharmacy Coverage Policies

None

Related Documents

Please refer to [CMS website](#) for the most current applicable National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA)/CMS Online Manual System/Transmittals.

Type	Title	ID Number	Jurisdiction Medicare Administrative	Applicable States/Territories
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Obstructive Sleep Apnea and Other Sleep Related Breathing Disorders Surgical Treatments

			Contractors (MACs)	
LCD	Surgical Treatment for Obstructive Sleep Apnea (OSA) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	<u>L34526</u> <u>L38528</u>	J5 - Wisconsin Physicians Service Insurance Corporation	All states except IN & MI
LCD	Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	<u>L38387</u>	J6 - National Government Services, Inc. (Part A/B MAC)	CT, IL, MA, ME, MN, NH, NY, RI, VT WI
LCD	Surgical Treatment for Obstructive Sleep Apnea (OSA) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	<u>L34526</u> <u>L38528</u>	J8 - Wisconsin Physicians Service Insurance Corporation	IN, MI
LCD	Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	<u>L38307</u>	J15 - CGS Administrators, LLC (Part A/B MAC)	KY, OH
LCD	Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	<u>L38310</u>	JE - Noridian Healthcare Solutions, LLC	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
LCD	Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	<u>L38312</u>	JF - Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
LCD	Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	<u>L38385</u>	JH - Novitas Solutions, Inc. (Part A/B MAC)	AR, CO, DE, DC, MD, NJ, NM, OK, PN, TX, LA, MS
LCA	Billing and Coding: Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	<u>A58075</u>	JJ - Palmetto GBA (Part A/B MAC)	AL, GA, NC, SC, TN, VA, WV
LCD	Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	<u>L38276</u>		

LCD	Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea	L38398	JN - First Coast Service Options, Inc. (Part A/B MAC)	FL, PR, U.S. VI
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Description

Obstructive sleep apnea (OSA) is a common sleep disorder in which the muscles of the soft palate and throat intermittently relax during sleep, creating an obstruction that blocks the upper airway. This causes breathing to become difficult and noisy (snoring). Individuals with OSA experience apnea (cessation of breathing) from 10 to 60 seconds at a time, which can occur up to 120 times an hour during sleep. As a result, oxygen levels in the bloodstream decrease, which may lead to abnormal heart rhythms, heart attack, high blood pressure and/or stroke.

Central sleep apnea (CSA) is a disorder characterized by repetitive cessation or decrease of both airflow and ventilatory effort during sleep. It can be primary (idiopathic CSA) or secondary. Examples of secondary CSA include CSA associated with Cheyne-Stokes breathing, a medical condition, a drug or substance or high-altitude periodic breathing. CSA associated with Cheyne-Stokes breathing is particularly common, especially among individuals who have heart failure or have had a stroke.⁶⁹

Upper airway resistance (UAR) syndrome is a type of sleep-disordered breathing involving increased airflow obstruction causing the individual to wake frequently, which can cause fatigue; however, UAR does not typically cause a decrease in oxygen saturation as does OSA.

Surgical treatments for OSA and other sleep related breathing disorders include, but may not be limited to, the following:

- **Cautery-assisted palatal stiffening operation (CAPSO)** is an office-based procedure, performed under local anesthesia, for the treatment of palatal snoring in which a portion of the soft palate is removed.
- **Drug induced sleep endoscopy (DISE)** is a diagnostic test that is done under sedation, usually in an operating room and evaluates the severity of airway blockage related to concentric collapse. If an individual has complete concentric collapse in their airway, both the soft palate (soft part of the roof of the mouth) and sides of the throat completely block the airway. Individuals with complete concentric collapse are not candidates for hypoglossal nerve stimulation.
- **Genioplasty (mentoplasty)** is surgery of the chin where a receding chin is altered with an implant or a prominent chin is reduced.
- **Hyoid myotomy and suspension** is a surgical procedure where an incision is-created in the neck and the hyoid bone, which is connected to the tongue base and epiglottis, is advanced and secured to stabilize the airway. This may be performed in combination with **genioglossus advancement**, a surgical procedure where the base of the tongue is pulled forward to increase the airway size.

- **Hypoglossal nerve stimulation (HGNS)** (eg, Inspire Upper Airway Stimulation [UAS] System) utilizes an implantable pulse generator, a respiratory-sensing lead and a stimulating lead surgically placed on the hypoglossal nerve. Mild electrical stimulation to the hypoglossal nerve produces selective motor stimulation of the muscle fibers that draw the tongue forward via activation of the genioglossus muscle, which improves upper airway obstruction. The individual uses a remote control to turn the device on before going to sleep and turn it off upon awakening. HGNS is intended to be a lifelong therapy.⁵⁷
- **Injection snoreplasty** is a procedure suggested for the treatment of snoring (not sleep disorders). It involves the injection of a hardening agent into the lining of the palate at the base of the uvula resulting in palatal stiffness, which purportedly reduces palatal flutter or primary snoring.
- **Laser-assisted uvulopalatoplasty (LAUP)** removes a portion of the soft palate and uvula with laser ablation to enlarge the naso-oropharyngeal opening. The laser technique reportedly allows surgeons to perform the procedure under local anesthesia on an outpatient basis.
- **Nasal surgery of the turbinate** (eg, cryotherapy, electrocautery, laser cautery, submucosal resection, submucous radiofrequency reduction, turbinectomy) for symptomatic nasal obstruction or turbinate hypertrophy is performed to supposedly reduce the size of the turbinate to decrease airway resistance, while preserving the natural function, which is to clean and humidify the air as it moves through the nose.
- **Palatal implants** (eg, Pillar Procedure) are intended to stiffen the structure of the soft palate. Three implants are inserted high up into the soft palate tissue under local anesthesia. The intended result is to change the airflow characteristics of the soft palate by stiffening and cause a reduction in airflow obstruction.
- **Phrenic nerve stimulation (PNS)** for moderate to severe CSA uses an implantable device (eg, remede System) that purportedly delivers unilateral transvenous stimulation to deliver diaphragmatic contraction that mimics normal breathing patterns. This approach is believed to help restore normal breathing patterns by stimulating the phrenic nerve, which innervates the diaphragm, allowing better oxygenation and improving sleep.⁵³
- **Radiofrequency volumetric tissue reduction (RFVTR)**, also referred to as coblation, Somnoplasty or submucosal ablation, is a surgical technique that utilizes radiofrequency ablation to produce finely controlled necrotic lesions to tissues of the soft palate, tongue, tonsils and turbinate. The necrosis purportedly leads to the formation of scar tissue, which upon healing should shrink and tighten, thereby reducing snoring and OSA.
- **Septoplasty** is the surgical correction of defects and deformities of the nasal septum (the partition between the nostrils).
- **Tongue base suspension procedure** (eg, AIRvance Tongue Suspension System, Encore Tongue Suspension System) suspends and repositions the tongue's anterior base and the hyoid bone to the mandible bone using bone screws and suspension sutures purportedly relieving upper airway obstruction.⁴⁹

- **Tonsillectomy and/or adenoidectomy are procedures performed for airway obstruction.** Tonsillectomy is the surgical removal of the tonsils, a collection of lymphoid tissue covered by mucous membranes on either side of the throat. An adenoidectomy is the surgical removal of the adenoid glands, which are masses of lymphoid tissue located at the back of the nose in the upper part of the throat.
- **Tracheostomy** is a surgical procedure in which an opening is created through the neck into the trachea (windpipe) and a tube placed through this opening to provide an airway.
- **Transpalatal advancement pharyngoplasty** is a procedure that was designed to surgically treat OSA in individuals that have narrowing in the retropalatal airway. Purportedly, the hard palate is excised and the soft palate is advanced anteriorly, which supposedly increases the retropalatal size and decreases retropalatal collapsibility.
- **Uvulectomy** is the surgical removal of the uvula. It may be performed as part of an uvulopalatopharyngoplasty (UPPP) if the uvula is enlarged in individuals diagnosed with OSA.
- **Uvulopalatopharyngoplasty (UPPP)** is the surgical revision of the posterior soft palate and adjacent tissue to relieve partial obstruction of the nasopharyngeal airway that causes OSA. Many surgeons perform this technique, but some perform a modification of it called **expansion sphincteroplasty**, or expansion sphincter pharyngoplasty (ESP). This technique stiffens the lateral pharyngeal walls and prevents its collapse in patients with OSA. While UPPP involves removal of the uvula, most surgeons performing the modified version preserve the majority if not the entire uvula.

Coverage Determination

iCare follows the CMS requirement that only allows coverage and payment for services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member except as specifically allowed by CMS.

In interpreting or supplementing the criteria above and in order to determine medical necessity consistently, iCare may consider the criteria contained in the following:

UPPP will be considered medically reasonable and necessary when all the following requirements are met³³:

- Confirmed diagnosis of OSA from a certified sleep disorder laboratory (respiratory disturbance index [RDI] of greater than or equal to 15); **AND**
- Documented continuous positive airway pressure (CPAP) therapy failure or intolerance* or other appropriate noninvasive treatment; **AND**
- Evidence of a retropalatal or combination retropalatal/retrolingual obstruction as the cause of the OSA

Genioglossal advancement with or without hyoid suspension will be considered medically reasonable and necessary when all the following requirements are met³³:

- Confirmed diagnosis of OSA from a certified sleep disorder laboratory (RDI of greater than or equal to 15); **AND**
- Documented CPAP therapy [failure or intolerance](#)* or other appropriate noninvasive treatment; **AND**
- Evidence of retrolingual obstruction as the cause of the OSA; **OR**
- Previous failure of UPPP to correct OSA

A **tracheostomy** will be considered medically reasonable and necessary when an individual has OSA that is unresponsive to other means of treatment or in cases where other means of treatment would be ineffective or not indicated at the discretion of the attending physician³³.

Surgeries to correct anatomic abnormalities of the upper airway (eg, enlarged tonsils, enlarged tongue) will be considered medically reasonable and necessary when documentation in medical records supports the significant contribution of these abnormalities to the individual's OSA³³.

Submucous radiofrequency turbinate reduction will be considered medically reasonable and necessary when the following requirements are met³³:

- Turbinate hypertrophy creates an obstruction that significantly contributes to OSA; **OR**
- Turbinate hypertrophy creates an obstruction that significantly compromises CPAP therapy

Expansion sphincteroplasty will be considered medically reasonable and necessary when all the following requirements are met:

- Confirmed diagnosis of OSA (apnea-hypopnea index [AHI] greater than 15); **AND**
- Documented CPAP therapy [failure or intolerance](#)*

A US Food & Drug Administration (FDA) approved **implantable upper airway hypoglossal nerve stimulation (HGNS) device** (eg, Inspire Upper Airway Stimulation System) will be considered medically reasonable and necessary when all the following requirements are met²⁵⁻³²:

- Absence of any [contraindications](#); **AND**

- Absence of any other anatomical findings that would compromise performance of the device (eg, tonsil size 3 or 4); **AND**
- Absence of complete concentric collapse at the soft palate level as seen on a drug-induced sleep endoscopy (DISE); **AND**
- Body mass index (BMI) is less than 35 kg/m²; **AND**
- Documentation that demonstrates CPAP failure or intolerance; **AND**
- Polysomnography (PSG) performed within 24 months of the consultation for an HGNS implant showing **BOTH** of the following:
 - AHI of 15-65 events per hour; **AND**
 - Individual has predominantly obstructive events (defined as central and mixed apneas less than 25% of the total AHI)

***CPAP failure** is defined as AHI greater than 15 despite CPAP usage. **CPAP intolerance** (defined as less than 4 hours per night, 5 nights per week or that the CPAP has been returned) including shared decision making that the individual was intolerant of CPAP despite consultation with a sleep expert. Shared decision making, by definition, is any documented conversation between and attending provider and the individual, and not between multiple providers.²⁶

Replacement or removal of an FDA-approved implantable upper airway HGNS device, generator battery, leads and/or remote will be considered medically reasonable and necessary when a previously implanted device, generator battery, leads and/or remote is no longer functioning appropriately and the device is no longer under warranty.

Drug induced sleep endoscopy (DISE) to determine whether HGNS would be appropriate will be considered medically reasonable and necessary when all the following requirements are met. Due to documented inconsistency in determining if complete concentric collapse (CCC) is present, the inserting provider shall be certified by the FDA-approved manufacturer's second opinion service of validation via video clip submissions of at least 80% agreement in at least 15 consecutive studies²⁵⁻³².

The use of the criteria in this Medicare Advantage Medical Coverage Policy provides clinical benefits highly likely to outweigh any clinical harms. Services that do not meet the criteria above are not medically necessary and thus do not provide a clinical benefit. Medically unnecessary services carry risks of adverse outcomes and may interfere with the pursuit of other treatments which have demonstrated efficacy.

Coverage Limitations

[US Government Publishing Office. Electronic code of federal regulations: part 411 – 42 CFR § 411.15 - Particular services excluded from coverage](#)

The following **surgical treatments for OSA** will not be considered medically reasonable and necessary:

- Cautery assisted palatal stiffening operation (CAPSO); **OR**
- Genioplasty; **OR**
- Injection snoreplasty; **OR**
- Laser assisted uvulopalatoplasty (LAUP); **OR**
- Nasal turbinate resection; **OR**
- Palatal implants (eg, Pillar Procedure); **OR**
- Radiofrequency volumetric tissue reduction (RVTR) (eg, Somnoplasty); **OR**
- Septoplasty; **OR**
- Submucosal radiofrequency ablation of the tongue base; **OR**
- Tongue-based suspension procedure (eg, AIRvance, Encore Tongue Suspension Systems); **OR**
- Transpalatal advancement pharyngoplasty; **OR**
- Uvulectomy as stand-alone treatment for OSA

A review of the current medical literature shows that the evidence is insufficient to determine that these services are standard medical treatment. There remains an absence of randomized, blinded clinical studies examining benefit and long-term clinical outcomes establishing the value of these services in clinical management.

Summary of Evidence

Cautery Assisted Palatal Stiffening Operation (CAPSO), Injection Snoreplasty, Palatal implants

A variety of palatal stiffening techniques have been studied, but they have minimal effect on OSA.⁷³ A literature search identified two randomized controlled trials (RCTs), a nonrandomized controlled study, and four uncontrolled studies that evaluated the Pillar Palatal Implant System for treatment of OSA. Results of these studies provide preliminary but somewhat inconsistent evidence that this procedure benefits individuals who have mild-to-moderate OSA. One RCT found that, compared with placebo treatment, palatal implantation provided statistically significant improvements in two measures of sleep quality. Comparable results were obtained in the uncontrolled studies of palatal implantation. Although these

results are promising, the magnitude of the benefits has not been large, the largest RCT found that average OSA worsened despite treatment, the available studies involved = 1 year of patient monitoring after treatment, and the RCTs compared palatal implants with placebo treatment rather than with other minimally invasive techniques for OSA treatment. Additional studies are needed to determine the role of the Pillar implant system in the management of OSA.⁵⁴

Genioplasty

There have been some studies evaluating genioplasty for the treatment of OSA. However, given the small number of studies, these procedures remain an area for additional OSA research. Just to not, UpToDate reviews on “Management of obstructive sleep apnea in adults” and “Overview of obstructive sleep apnea in adults” do not mention genioplasty as therapeutic options for OSA.^{72,73}

Laser Assisted Uvulopalatoplasty (LAUP), Uvulectomy (stand-alone treatment for OSA)

First introduced in the United States in 1993, LAUP competes with (UPPP) for treating snoring associated with OSA and UARS. LAUP is performed with local anesthesia and does not require sedation. UPPP is a surgical procedure that requires general anesthesia. LAUP requires 1-5 sequential treatment sessions (depending on the type of laser used), staged 4-8 weeks apart to sufficiently reshape the uvula and soft palate. LAUP and UPPP also compete with radiofrequency tissue reduction, a procedure that uses radiofrequency energy to reduce the volume of the soft palate and uvula. The effectiveness of LAUP for treating sleep-disordered breathing conditions such as OSA and UARS continue to be investigated.⁴⁵ Partial or complete removal of the uvula by uvulectomy or LAUP may be a part of the UPPP procedure, another surgical intervention for OSA or other breathing-related sleep disorders, but there is not enough published peer-review literature to evaluate the evidence related to uvulectomy alone as a treatment for OSA.⁵²

Nasal Turbinate Resection, Septoplasty

Nasal surgery as a stand-alone procedure does not reliably treat OSA. Evidence of nasal surgery's benefit as an adjunctive procedure is mainly observational series.

A systematic review of the effect of isolated nasal surgery on CPAP device use and therapeutic pressures identified 18 studies in 279 individuals. In seven studies (82 patients) that reported baseline and postoperative device pressure settings, nasal surgery reduced mean CPAP therapeutic pressure from 12 to 10 centimeters of water pressure. Clinical outcomes were variably reported; in a subgroup analysis of 11 studies that included self-reported data on CPAP use, 89 percent of 64 individuals who were not using CPAP before surgery were subsequently able to accept, adhere to or tolerate CPAP after surgery.

In a randomized pilot study, 22 patients with turbinate hypertrophy and difficulty tolerating CPAP were randomly assigned to radiofrequency turbinate reduction or sham control. Compared with the control group, individuals who underwent turbinate reduction had significantly improved self-reported CPAP adherence and a trend towards improved objective CPAP use (between-group difference of 32 minutes per night).⁷³

Radiofrequency Volumetric Tissue Reduction (RVTR)

Radiofrequency ablation appears to improve sleep and reduce OSA symptoms in patients with mild to moderate OSA at up to 1-year follow-up; however, results are inconclusive because available studies (1

systematic review [SR] of mostly small before-and-after treatment studies and 4 additional before-and-after treatment studies all at high of bias) provide very-low-quality evidence and limited data on whether OSA symptom improvements are sustained beyond 1 year. One randomized controlled trial (RCT) and 1 nonrandomized comparison study assess too few patients and are at too high a risk of bias to determine how well RFA works compared with uvulopalatopharyngoplasty and other surgical procedures for treating mild and moderate OSA.⁴²

Submucosal Radiofrequency Ablation of the Tongue Base, Tongue-Based Suspension Procedure

Radiofrequency tongue reduction is a minimally invasive procedure. It creates a submucosal scar that stiffens the tissue and reduces tongue volume by a mean of 17 percent after five treatment sessions. Compared with surgical excision techniques, minimally invasive radiofrequency reduction procedures offer simpler recovery but are generally less effective. A randomized, placebo-controlled trial of radiofrequency tongue and palate reduction demonstrated an improvement in the primary outcome of sleep-related quality of life using validated instruments and a statistical trend of improvement in reaction times, compared with sham radiofrequency ablation. In contrast, the AHI did not improve significantly compared with baseline (mean decrease of 5 from a baseline of 21 per hour), although the apnea index did, possibly suggesting a physiologic shift of apneas to hypopneas. In a long-term follow-up study, the benefits persisted for at least two years.⁷³

Only one study was identified for the Encore Suspension System and the evidence was inconclusive. The study had many limitations including a small sample size and no control group, independent study validation, outcomes or comparison data.⁴⁹

Transpalatal Advancement Pharyngoplasty

Uvulopalatopharyngoplasty (UPPP) success rates in individuals classified with Friedman stage 3 are reported as 8%. Surgical failure may result from persistent obstruction at the palate, which may be addressed by pharyngoplasty with palatal advancement (PA). PA may offer benefit over UPPP alone some individuals, however, there has not been as much research on this approach as others.⁷³

Hypoglossal nerve stimulation (HGNS) (eg, Inspire Upper Airway Stimulation System) will not be considered medically reasonable and necessary for the following contraindications²⁵⁻³²:

- **ANY** of the following conditions:
 - An active, serious mental illness that reduces the ability to carry out activities of daily living (ADLs) and would interfere with the individual's ability to operate the HGNS or report problems
 - Coexisting nonrespiratory sleep disorders that would confound functional sleep assessment
 - Compromised neurological control of the upper airway
 - Hypoglossal nerve palsy
 - Moderate-to-severe pulmonary arterial hypertension
 - New York Heart Association class III or IV heart failure
 - Neuromuscular disease
 - Persistent uncontrolled hypertension despite medication use
 - Recent (within the past 6 months) myocardial infarction or severe cardiac arrhythmias
 - Severe restrictive or obstructive pulmonary disease; **OR**

- BMI greater than or equal to 35; **OR**
- Central and mixed apneas greater than 25% of the AHI; **OR**
- Individual who is pregnant or plans to become pregnant; **OR**
- Individual who is unable or does not have the necessary assistance to operate the sleep remote; **OR**
- Individual with a condition that requires or is likely to require future magnetic resonance imaging (MRI) (unless the HGNS device is MRI-compatible); **OR**
- Individual with an already implanted device that may be susceptible to unintended interaction with the system

A review of the current medical literature shows that the evidence is insufficient to determine that this service is standard medical treatment for an individual with these contraindications. There remains an absence of randomized, blinded clinical studies examining benefit and long-term clinical outcomes if performing this procedure when the above contraindications are present.

Central sleep apnea (CSA) surgical treatments including, but may not be limited to, **phrenic nerve stimulation** (eg, remede System) will not be considered medically reasonable and necessary. A review of the current medical literature shows that the evidence is insufficient to determine that this service is standard medical treatment. There remains an absence of randomized, blinded clinical studies examining benefit and long-term clinical outcomes establishing the value of this service in clinical management.

Summary of Evidence

Phrenic Nerve Stimulation

Studies demonstrate remede is safe and report consistent findings that remede improves outcomes from baseline in individuals with moderate to severe CSA and that those benefits are sustained long term. However, some study limitations restrict findings generalizability. Some studies included in the systematic review (SR) are at elevated risk of bias; individuals in the RCT's inactive stimulation arm received active stimulation after 6 months; therefore, the study was no longer an RCT, and the risk of bias for outcomes after 6 months increased. Controlled trials that compare remede with alternative treatment options for patients with moderate to severe CSA and report on long-term (greater than 5 years) outcomes are needed to assess remede's comparative safety and effectiveness.⁴³

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

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CPT® Code(s)	Description	Comments
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	
21121	Genioplasty; sliding osteotomy, single piece	
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	
21198	Osteotomy, mandible, segmental;	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	
21685	Hyoid myotomy and suspension	
30130	Excision inferior turbinate, partial or complete, any method	
30140	Submucous resection inferior turbinate, partial or complete, any method	
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)	
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	
31600	Tracheostomy, planned (separate procedure);	
31601	Tracheostomy, planned (separate procedure); younger than 2 years	
41512	Tongue base suspension, permanent suture technique	
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	
42140	Uvulectomy, excision of uvula	
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	
42299	Unlisted procedure, palate, uvula	
42820	Tonsillectomy and adenoidectomy; younger than age 12	
42821	Tonsillectomy and adenoidectomy; age 12 or over	

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42825	Tonsillectomy, primary or secondary; younger than age 12	
42826	Tonsillectomy, primary or secondary; age 12 or over	
42830	Adenoidectomy, primary; younger than age 12	
42831	Adenoidectomy, primary; age 12 or over	
42835	Adenoidectomy, secondary; younger than age 12	
42836	Adenoidectomy, secondary; age 12 or over	
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	
42975	Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing, flexible, diagnostic	
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	
64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	
64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	
64585	Revision or removal of peripheral neurostimulator electrode array	
64999	Unlisted procedure, nervous system	

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95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	
CPT® Category III Code(s)	Description	Comments
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)	
0425T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only	
0426T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only	
0427T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only	
0428T	Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only	
0429T	Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only	
0430T	Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only	
0431T	Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only	
0432T	Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only	

0433T	Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only	
0434T	Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea	
0435T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session	
0436T	Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study	
HCPCS Code(s)	Description	Comments
C1767	Generator, neurostimulator (implantable), nonrechargeable	
C1778	Lead, neurostimulator (implantable)	
C1787	Patient programmer, neurostimulator	
C1823	Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads	
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	
C9727	Insertion of implants into the soft palate; minimum of three implants	
L8680	Implantable neurostimulator electrode, each	
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension	

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Change Summary

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