BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	**MANUAL:** MEDICAL POLICY
	REFERENCE NO.: MPO-490-0035
EFFECTIVE DATE October 1, 2014	**SUBJECT:** Sleep Disorder Services

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure. In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

Sleep Studies and Polysomnography refer to the monitoring and recording of sleep patterns.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

Coverage is subject to the terms, conditions, and limitations of the member's contract.

Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome (OSA)

A. BCNEPA will provide coverage for supervised polysomnography when medically necessary.

1. Supervised polysomnography (PSG) performed in a sleep laboratory may be considered medically necessary as a diagnostic test in patients with any of the following (a-c):

   a) Observed apneas during sleep; or

   b) A combination of at least two of the following (1-5):

      (1) Excessive daytime sleepiness evidenced by an Epworth Sleepiness Scale greater than 10, inappropriate daytime napping (e.g., during driving, conversation, or eating), or sleepiness that interferes with daily activities and is not explained by other conditions, (this may be expressed as learning difficulties or other daytime neurobehavioral problems in young children);

      (2) Habitual snoring, or gasping/choking episodes associated with awakenings;

      (3) Unexplained hypertension;

      (4) Obesity, defined as a body mass index greater than 35 kg/m2 in adults or greater than the 90th percentile for the weight/height ratio in pediatric patients;

      (5) Craniofacial or upper airway soft tissue abnormalities, including adenotonsillar hypertrophy, or neuromuscular disease.

   c) OR; moderate or severe congestive heart failure, stroke/transient ischemic attack, coronary artery disease, or significant tachycardia or bradycardic arrhythmias in patients who have nocturnal symptoms suggestive of a sleep-related breathing disorder or otherwise suspected of having sleep apnea.

2. Repeat supervised polysomnography performed in a sleep laboratory may be considered medically necessary under the following circumstances:

   a) To initiate and titrate continuous positive airway pressure (CPAP) in adult patients with clinically significant OSA defined as those patients who have:

      (1) An apnea/hypopnea index (AHI) of at least 15 per hour; or

      (2) An AHI of at least 5 per hour in a patient with excessive daytime sleepiness or unexplained hypertension.

   Notes:

   - In pediatric patients, an AHI > 1.5 is considered abnormal, and an AHI of 15 is considered severe.

- Clinically significant OSA is defined as those pediatric patients who have:
  - AHI or RDI of at least 5 per hour, or
  - AHI or RDI of at least 1.5 per hour in a patient with excessive daytime sleepiness, behavioral problems or hyperactivity.
- A split-night study, in which severe OSA is documented during the first portion of the study using polysomnography, followed by CPAP during the second portion of the study, can eliminate the need for a second study to titrate CPAP (See Definitions - AASM Practice Parameters for criteria).
- Respiratory disturbance index may be used in place of AHI in unattended sleep studies.

b) Failure of resolution of symptoms or recurrence of symptoms during treatment; or

c) To assess efficacy of surgery (including adenotonsillectomy) or oral appliances/devices; or

d) To reevaluate the diagnosis of obstructive sleep apnea and need for continued CPAP, e.g., if there is a significant change in weight or change in symptoms suggesting that CPAP should be retitrated or possibly discontinued.

3. Requests for supervised polysomnography not meeting criteria outlined above will be considered not medically necessary.

B. BCNEPA will not provide coverage for multiple sleep latency testing in the diagnosis of obstructive sleep apnea except to exclude or confirm suspected narcolepsy in the diagnostic workup of obstructive sleep apnea syndrome (OSA) as this is considered not medically necessary.

Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome

C. BCNEPA will provide coverage for surgical intervention of sleep apnea when medically necessary as described below.

1. Uvulopalatopharyngoplasty (UPPP) may be considered medically necessary for the treatment of clinically significant obstructive sleep apnea syndrome (OSA) in appropriately selected adult patients who have not responded to or do not tolerate nasal CPAP.

2. Hyoid suspension, surgical modification of the tongue, and/or maxillofacial surgery, including mandibular-maxillary advancement (MMA) may be considered medically necessary in appropriately selected adult patients with clinically significant OSA and objective documentation of hypopharyngeal obstruction who have not responded or do not tolerate CPAP.

3. Adenotonsillectomy may be considered medically necessary in children with OSA and hypertrophic tonsils.

4. Surgical treatment of OSA that does not meet the criteria above would be considered not medically necessary.

D. BCNEPA will not provide coverage for the following minimally-invasive procedures for the sole or adjunctive treatment of obstructive sleep apnea (OSA) or upper airway resistance syndrome as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:

1. Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues;

2. Laser assisted palatoplasty (LAUP) or radiofrequency volumetric tissue reduction of the palatal tissues;

3. Palatal stiffening procedures including, but not limited to, cautery-assisted palatal stiffening operation, injection of a sclerosing agent, and the implantation of palatal implants;

4. Tongue base suspension; or

5. All other indications not identified above as medically necessary.

E. BCNEPA will not provide coverage for implantable hypoglossal nerve stimulators as they are considered investigational for all indications, including but not limited to the treatment of OSA.

F. BCNEPA will not provide coverage for all interventions, including LAUP, radiofrequency volumetric tissue reduction of the palate, or palatal stiffening procedures for the treatment of snoring in the absence of documented OSA or UARS as this is considered not medically necessary. Snoring alone is not considered a medical condition.

IV. DEFINITIONS:

Apnea: cessation of airflow for at least 10 seconds.

Apnea/Hypopnea Index (AHI): is the total number events (apnea or hypopnea) per hour of recorded sleep.

Clinically Significant OSA – Adult Patients: defined as those patients who have:

- Apnea/hypopnea index (AHI) or respiratory disturbance index (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.

Clinically Significant OSA – Pediatric Patients: defined as those patients who have:

- AHI or RDI of at least 5 per hour, or
- AHI or RDI of at least 1.5 per hour in a patient with excessive daytime sleepiness, behavioral problems or hyperactivity.

Continuous Positive Airway Pressure (CPAP): a non-invasive technique for providing low levels of air pressure from a flow generator, via a nose mask, through the nares.

Hypersomnia (excessive daytime sleepiness): sleeping for pathological lengths of time. May be associated with psychiatric illness, drug or alcohol use, or narcolepsy.

Hypopnea: 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.

Insomnia: inability to sleep at a time when the person expected sleep to occur. The difficulty may be in either falling asleep or remaining asleep, or both. The disorder may be primary or secondary to some other illness, condition, or circumstance.

Myoclonus: twitching or clonic spasm of a muscle or group of muscles.

Narcolepsy: characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep.

Obstructive Hypopneas: reductions but not cessation of air exchange, with an associated fall in oxygen saturation (at least 3%-4%) or arousal.

Obstructive Apnea: is defined as at least 10 seconds cessation of respiration associated with ongoing ventilatory effort.

Obstructive Sleep Apnea (OSA) Syndrome: characterized by repetitive episodes of upper airway obstruction that occurs during sleep, usually associated with a reduction in blood oxygen saturation and with associated daytime sleepiness. The diagnosis of OSA requires documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, during 6-7 hours of recorded sleep.

Palatopharyngoplasty (PPP): a plastic surgical procedure for increasing the nasopharyngeal passageway. It has been used in treating chronic snoring.

Parasomnia: a condition that represents undesirable or unpleasant occurrences during sleep may include conditions such as sleep walking, sleep terrors, and "rapid-eye-movement" (REM) sleep behavior disorders.

Respiratory Disturbance Index (RDI): the total number events (apnea or hypopnea) per hour of recording time.

Sleep Apnea: potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described (central, obstructive and mixed).

Sleep Disorder Clinics/Sleep Laboratory: facilities in (either free standing or hospital affiliated) in which certain illnesses may be diagnosed through the study of sleep. The clinics can also provide

therapeutic services for some sleep related conditions.

Split-night Study: initial diagnostic polysomnography (PSG) followed by CPAP titration during PSG on the same night. American Academy for Sleep Medicine (AASM) Practice Parameters criteria must be met:

- An AHI of at least 40 is documented during a minimum of 2 hours of diagnostic PSG. Split-night studies may sometimes be considered at an AHI of 20 to 40, based on clinical judgment (e.g., if there are also repetitive long obstructions and major desaturations). However, at AHI values below 40, determination of CPAP pressure requirements, based on split-night studies, may be less accurate than in full-night calibrations.

- CPAP titration is carried out for more than 3 hours (because respiratory events can worsen as the night progresses).

- PSG documents that CPAP eliminates or nearly eliminates the respiratory events during rapid eye movement (REM) and non-REM (NREM) sleep, including REM sleep with the patient in the supine position.

- A second full night of PSG for CPAP titration is performed if the diagnosis of a sleep-related breathing disorder (SRBD) is confirmed, but criteria b and c are not met.

- Uvulopalatopharyngoplasty (UPPP): plastic surgery of the oropharynx in which redundant soft palate, uvula, pillars, fauces, and sometimes posterior pharyngeal wall mucosa are removed. This procedure is usually done to correct intractable snoring or sleep apnea.

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CODING:

- **The identification of a code in this section does not denote coverage or separate reimbursement.**
- Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.
- The following list of codes may not be all-inclusive, and are subject to change at any time.
- Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

PROCEDURE CODES

41512	42145	95783	95807	95810	S2080
41530	95782	95805	95808	C9727	