Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Surgical Procedures for the Treatment of Obstructive Sleep Apnea

Effective: September 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Overview

Obstructive sleep apnea (OSA), the most common form of sleep apnea, is the collapse of the upper airway leading to the reduction or cessation of airflow during sleep. Oral surgeries are used to treat obstructive sleep apnea (OSA) by opening airways or removing obstructions.

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations. For Tufts Health One Care plan members the following criteria is used for the services of maxillomandibular Advancement (MMA)/ Mandibular Advancement (MA), Genioglossus Advancement (GA)/Hyoid Suspension, and uvulopalatopharyngoplasty (UPPP): LCD - Surgical Treatment of Obstructive Sleep Apnea (OSA) (L34526) (cms.gov) is being supplemented to provide additional detail regarding medical necessity criteria for its Dual Product Eligible plan members.

For the service of Treating Obstructive Sleep Apnea with a hypoglossal nerve stimulator, evidence is sufficient for coverage. The criteria used for hypoglossal nerve stimulator below is based upon the Stimulation Treatment for Apnea Reduction (STAR) study and current FDA guidance to provide additional guidance for Members with OSA.

The use of this criterion in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

Clinical Guideline Coverage Criteria

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for Uvuloplatopharyngoplasty.

1. Uvuloplatopharyngoplasty (UPPP)

In addition, The Plan requires the following criteria for:

1. Maxillomandibular advancement (MMA)/ Mandibular Advancement (MA)
2. Genioglossus Advancement/ Hyoid Suspension
3. Hypoglossal Nerve Stimulation.

General Eligibility Criteria for Maxillomandibular Advancement, Mandibular Advancement, Genioglossus Advancement, and Hyoid Suspension:

The Plan considers Maxillomandibular Advancement, Mandibular Advancement, Genioglossus Advancement and Hyoid Suspension as medically necessary when ALL of the following General Eligibility criteria are met:

1. Polysomnography or home sleep study confirms one of the following:
    a. Diagnosis of moderate to severe OSA (AHI/RDI > 15), or;
    b. Symptomatic mild OSA (AHI/RDI 5-14) with ANY of the following:
        i. Epworth Sleepiness Scale score > 9
        ii. Excessive daytime sleepiness
        iii. Impaired cognition
        iv. Mood Disorder
        v. Insomnia
        vi. Hypertension
        vii. Ischemic Heart Disease
        viii. History of Stroke
2. Medical record includes evidence of the failure of prior medical treatment for OSA:
    a. Documentation from a sleep specialist certified by an approved specialty board of the American Board of Medical Specialties (e.g., ABIM), that the member has had a previous trial of positive airway pressure (PAP) device that failed or was not tolerated for the ONE or more of the following:
        i. Significant clinical improvement was not demonstrated with a trial of PAP; or
        ii. The device trialed could not be tolerated because of claustrophobia, inability to breathe through nose, pain or increasing levels of discomfort; or
        iii. Documentation of continued complaint of pressure discomfort which precludes proper use of CPAP and is unable to be resolved (e.g., pressure and interface adjustments); and
        iv. Attempts to resolve reason(s) for PAP failure/intolerance, including but not limited to poor mask fit,

excessive leak, adjustments in humidification and improper treatment settings, have failed

3. Member has been informed of the use of an oral appliance as an alternative to surgery for treatment of OSA

Service Specific Criteria

Surgical Procedure	Criteria
• **Maxillomandibular Advancement (MMA)** • **Mandibular Advancement (MA)** Surgical procedures performed to correct retrolingual or hypopharyngeal obstruction by moving the jaw(s) and base of the tongue forward to increase the size of the posterior airway space.	Procedures are authorized as follows: 1. Documentation confirms member meets the general eligibility criteria; AND 2. Documentation* confirms craniofacial skeletal abnormalities for which correction of those abnormalities is expected to significantly improve OSA; OR a. *Required documentation includes lateral cephalometric radiographs with tracings, measurements and predictions, or 3D CT scan of the upper airway. 3. When requested for a member whose OSA failed to sufficiently improve following other surgical procedures for OSA (Confirmation by polysomnography or home sleep study within the past year is required.)
• **Genioglossus Advancement (GA)** [May include Hyoid Myotomy and Suspension (GAHM)] Surgical procedure where the base of the tongue is pulled forward to better open the airway to treat OSA, usually to increase airway size due to deformity. The procedure is sometimes performed with hyoid myotomy and suspension (GAHM) when both are indicated. • GA is also frequently performed with Maxillomandibular advancement or mandibular advancement procedures.	Procedures are authorized as follows: 1. Documentation confirms members meet the general eligibility criteria; AND 2. Documentation* confirms hypopharyngeal soft tissue and tongue-base abnormalities that are causing significant airway obstruction. OR a. *Required documentation includes lateral cephalometric radiographs with tracings, measurements and predictions, or 3D CT scan of the upper airway. 3. Requested procedure may be performed with, or after, MMA/MA or UPPP procedures for members whose OSA has failed to sufficiently improve (Confirmation by polysomnography or home sleep study within the past year is required)

Hypoglossal Nerve Stimulation

The Plan may cover hypoglossal nerve stimulation implantation procedures when **ALL** of the following criteria are met:

1. Member is 18 years of age or older; **and**
2. Body Mass Index (BMI) is less than or equal to 40 kg/m^2; **and**
3. A polysomnography (PSG) performed no more than 24 months prior to the consultation for HGNS implant confirms:
    a. Moderate to severe obstructive sleep apnea (OSA) with apnea hypopnea index (AHI) is 15 to 100 events per hour; **and**
    b. Predominantly obstructive events, defined as central and mixed apneas less than 25 percent of the total AHI
4. Member has trialed continuous PAP (CPAP) and/or bi-level PAP within the previous 24 months **and** for a minimum of three months, AND documented failure and/or intolerance to CPAP and/or bi-level PAP is confirmed by the following:
    a. Continued AHI greater than 15 despite compliant use of CPAP and/or bi-level PAP 4 or more hours per night, 5 or more nights per week; **and/or**
    b. Inability to tolerate CPAP and/or bi-level PAP a minimum of four or more hours per night, five or more nights per week; **and**
    c. Failure of and/or intolerance to CPAP/bi-level PAP despite consultation with a sleep specialist certified by an approved specialty board of the American Board of Medical Specialties (e.g., ABIM):
        i. Attempts to resolve reason(s) for failure/intolerance, including but not limited to poor mask fit,

excessive leak, adjustments in humidification and improper treatment settings; **and**

ii. Alternative non-invasive treatments for treatment of OSA, after failure or intolerance of CPAP and/or bi-level PAP, were considered and these non-invasive treatments failed or were deemed inappropriate. Alternative non-invasive treatments include but are not limited to oral appliance therapy, positional therapy and/or weight loss

NOTE: Facility PAP titration study and unattended auto-titration of PAP (APAP) do not qualify as required 3-month trial of CPAP/bi-level PAP device

5. Surgical consultation indicating absence of complete concentric collapse at the soft palate level as seen on a drug induced sleep endoscopy (DISE) procedure; **and**
6. DISE procedure identifies no anatomical findings that would compromise performance of device (e.g., tonsil size three or four per standardization tonsillar hypertrophy grading scale)

The Plan may cover hypoglossal nerve stimulation implantation procedures for members with Down Syndrome when **ALL** of the following criteria are met:

1. Member is 13 years of age or older; **AND**
2. A polysomnography (PSG) performed no more than 24 months prior to the consultation for HGNS implant confirms:
    a. Moderate to severe obstructive sleep apnea (OSA) with apnea hypopnea index (AHI) is between 10-50 events per hour; **AND**
3. Member has trialed continuous PAP (CPAP) and/or bi-level PAP within the previous 24 months **and** for a minimum of three months, AND documented failure and/or intolerance to CPAP and/or bi-level PAP is confirmed by the following:
    a. Continued AHI greater than 15 despite compliant use of CPAP and/or bi-level PAP 4 or more hours per night, 5 or more nights per week; **and/or**
    b. Inability to tolerate CPAP and/or bi-level PAP a minimum of four or more hours per night, five or more nights per week; **and**
    c. Failure of and/or intolerance to CPAP/bi-level PAP despite consultation with a sleep specialist certified by an approved specialty board of the American Board of Medical Specialties (e.g., ABIM): :
        i. Attempts to resolve reason(s) for failure/intolerance, including but not limited to poor mask fit, excessive leak, adjustments in humidification and improper treatment settings; **and**
        ii. Alternative non-invasive treatments for treatment of OSA, after failure or intolerance of CPAP and/or bi-level PAP, were considered and these non-invasive treatments failed or were deemed inappropriate. Alternative non-invasive treatments include but are not limited to oral appliance therapy, positional therapy and/or weight loss

    NOTE: Facility PAP titration study and unattended auto-titration of PAP (APAP) do not qualify as required 3-month trial of CPAP/bi-level PAP device
4. Surgical consultation indicating absence of complete concentric collapse at the soft palate level as seen on a drug induced sleep endoscopy (DISE) procedure; **AND**
5. DISE procedure identifies no anatomical findings that would compromise performance of device (e.g., tonsil size three or four per standardization tonsillar hypertrophy grading scale)

**Individuals with certain Inspire stimulator models may not be eligible for MRI scans. Refer to MRI guidelines for Inspire Therapy manual: manuals.inspiresleep.com*

NOTE: Refer to the following Medical Necessity Guidelines for treatment of disorders not related to Obstructive Sleep Apnea

- Orthognathic Surgery for Severe Oral-Maxillofacial Functional Disorders
- Temporomandibular Joint (TMJ) Disorder Treatment

Limitations

The Plan does not cover the following procedures:

1. Tongue base suspension, permanent suture technique, e.g., AIRvance Bone Screw System; CPT code 41512
2. Repose System
3. Laser-Assisted Uvulo-Palatoplasty (LAUP) - CPT code S2080
4. Pillarâ Palatal Implant System - C9727

5. Reduction of Base of Tongue (RBOT)
6. Somnoplasty of the soft palate - CPT unlisted code 42299
7. Transoral robotic surgery
8. Surgical treatment for snoring alone
9. Uvulectomy
10. Laser assisted Uvulopalatoplasty (UPP)
11. Submucosal ablation of the tongue base; CPT code 41530
12. Facility PAP titration study and unattended auto-titration of PAP (APAP) do not qualify as a trial of PAP
13. Implantation of non-FDA approved hypoglossal nerve neurostimulation device
14. Implantation of HGNS device for indications other than above
15. The Plan will not cover the HGNS implantation when the Member has any of the following:
    a. BMI greater than 40 kg/m
    b. Neuromuscular disease affecting the respiratory system
    c. Hypoglossal-nerve palsy
    d. Severe restrictive or obstructive pulmonary disease
    e. Moderate to severe pulmonary arterial hypertension
    f. Severe valvular heart disease
    g. NYHA class III or IV heart failure
    h. Recent myocardial infarction or severe cardiac arrhythmias (within the past 6 months)
    i. Persistent uncontrolled hypertension despite medication use
    j. An active, serious mental illness that reduces the ability to carry out Activities of Daily Living (ADLs) and would interfere with the patient's ability to operate the HNS and report problems to the attending provider
    k. Coexisting non-respiratory sleep disorders that would confound functional sleep assessment
    l. Members with any condition or procedure that has compromised neurological control of the upper airway
16. Member is unable or does not have the necessary assistance to operate the sleep remote
17. Member is, or is planning to become pregnant

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes – Maxillomandibular Advancement, Mandibular Advancement, Genioglossus Advancement, and Hyoid Suspension

Code	Description
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental;
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)

Table 2: CPT/HCPCS Codes – Hypoglossal Nerve Stimulation

Code	Description
64568	Incision for implantation of cranial nerve (e.g., 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
*C8007	Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring insertion of a separate distal respiratory sensor electrode or electrode array
*C8011	Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including

Code	Description
	external power source and all system components

*PA required for or HPHC Commercial, THP Commercial, Direct, MA Together, RITogether only

The Plan will be using InterQual SmartSheet(s) for the following procedure code(s)

Table 3: CPT/HCPCS Codes – Uvuloplatopharyngoplasty (UPP)

Code	Description
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopalatoplasty)

References:

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3. Continuous positive airways pressure for obstructive sleep apnea in adults. Cochrane Database System Review. 2006; July 19: 3.
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9. Kline, LR. Clinical presentation and diagnosis of obstructive sleep apnea in adults. In: UpToDate, Post, TS (ed), Waltham, MA, 2015.
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16. Hayes A TractManager Company. Hypoglossal Nerve Stimulation for the Treatment of Obstructive Nerve Stimulation. Health Technology Assessment. October 30, 2018. Annual Review October 25, 2019. Last accessed August 17, 2020 at evidence.hayesinc.com/report/dir.hypoglossal2981.
17. Patil SP, Ayappa IA, et. Al. Treatment of Adult Obstructive Sleep Apnea with Positive Airway Pressure: An American Academy of Sleep Medicine Clinical Practice Guideline. J Clin Sleep Med. 2019;15(2):335–343.
18. Kapur VK, Auckley DH, Chowdhuri S, et al. Clinical Practice Guideline for Diagnostic Testing for Adult Obstructive Sleep Apnea: An American Academy of Sleep Medicine Clinical Practice Guideline. J Clin Sleep Med. 2017; 13 (3):479–504.
19. Woodson BT, Strohl KP, Soose RJ, et al. Upper Airway Stimulation for Obstructive Sleep Apnea: 5-Year Outcomes. Otolaryngol Head Neck Surg. 2018 Jul; 159 (1):194-202.
20. Heiser C, Steffen A, Boon M, et al. Post-approval upper airway stimulation predictors of treatment effectiveness in the ADHERE registry. Eur Respir J 2019; 53: 1801405.
21. Withrow K, Evans S, et.al. Upper Airway Stimulation Response in Older Adults with Moderate to Severe Obstructive Sleep Apnea. Otolaryngol Head Neck Surg 2019; 1-6.

22. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD) for Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387). Last accessed on August 17, 2021 at cms.gov/medicare-coverage

Approval And Revision History

June 17, 2020: Reviewed by IMPAC, renewed with no changes

Subsequent endorsement date(s) and changes made:

- July 1, 2020: Fax number for Unify updated
- February 17, 2021: Reviewed by IMPAC, renewed with no changes
- May 19, 2021: Reviewed by IMPAC, renewed with no changes
- February 16, 2022: Reviewed by MPAC, renewed without changes
- May 18, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), updated to include criteria for Maxillomandibular Advancement, Mandibular Advancement, Genioglossus Advancement, and Hyoid Suspension. MNG name updated to "Surgical Procedures for the Treatment of Obstructive Sleep Apnea"; criteria added for hypoglossal nerve stimulation for Integration between Harvard Pilgrim Health Care and Tufts Health Plan for April 1, 2023, effective date
- May 17, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Reviewed and approved by the UM Committee, effective January 1, 2024
- February 21, 2024: Reviewed by MPAC, renewed without changes effective April 1, 2024
- June 13, 2024: Reviewed and approved by UM Committee effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for IQ update for UPPP, criteria for Hypoglossal Nerve Stimulation updated – Members aged 18 years will be eligible for HGNS, BMI increased to less than or equal to 40, AHI range increased to 15-100 events per hour; Criteria added for hypoglossal nerve stimulation for Members aged 13-18 years old with pediatric downs syndrome; One Care criteria updated to use the Plan's criteria, effective August 1, 2024
- February 19, 2025: Reviewed by MPAC, renewed without changes, effective April 1, 2025
- May 21, 2025: Reviewed by MPAC for 20205 InterQual Upgrade, effective July 1, 2025
- June 18, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- June 18, 2025: Reviewed by MPAC, language regarding sleep specialists for Hypoglossal Nerve Stimulation clarified, effective August 1, 2025
- July 21, 2025: Template updated, language for Carelink removed
- March 18, 2026, Reviewed at MPAC. Annual Review effective May 1, 2026. Codes C8007 and C8011 added to PA for HPHC Commercial, THP Commercial, Direct, MA Together, RITogether.
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026
- July 15, 2026: Reviewed by MPAC for annual review, renewed without changes effective September 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management

guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.