MEDICAL POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea-MP-MM-1423	05/01/2024
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

agreement in at least 15 consecutive studies. Inserting providers shall have documentation to submit to this contractor if necessary.

- **Hypoglossal Nerve** – The twelfth cranial nerve that stimulates all the extrinsic and intrinsic muscles of the tongue, except for the palatoglossus, which is stimulated by the vagus nerve.
- **Obstructive Sleep Apnea (OSA)** – A disease characterized by recurrent episodes of upper airway obstruction during sleep.
- **Polysomnography (PSG)** – The gold standard lab test used to diagnose obstructive sleep apnea.

D. Policy

I. CareSource considers HGNS for the treatment of moderate to severe OSA medically necessary when **ALL** of the following clinical criteria are met:

A. A pulmonary specialist, internal medicine provider or sleep medicine specialist verifies the member is eligible for treatment.
B. If the member has a cardiac condition, this requires clearance from their cardiologist.
C. The member is 18 years of age or older.
D. Body mass index (BMI) is less than 35

B. Non-FDA-approved HGNS is considered not medically reasonable and necessary for the treatment of adult OSA due to insufficient evidence of being safe and effective.
C. HGNS is considered **not** medically reasonable and necessary when **ANY** of the following contraindications are present:
    1. Members with central and mixed apneas that make up more than one-quarter of the total AHI
    2. Members with an implantable device could experience unintended interaction with the HGNS implant system
    3. BMI greater than 35
    4. Neuromuscular disease
    5. Hypoglossal-nerve palsy
    6.

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