Henry Mayo Newhall Hospital

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# Hypoglossal Nerve Stimulation
# For the Treatment of Obstructive Sleep Apnea

**Patient Name: _____DOB _____**

**ICD-10-CM Diagnosis Code:**

| | |
|---|---|
| | **G47.33 Obstructive sleep apnea (adult) (pediatric)** |

**Covered Indications**

**All** of the following criteria are met:

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|---|---|
| | 1. Beneficiary is 22 years of age or older; **Age: _____ and** |
| | 2. Body mass index (BMI) is less than 35 kg/m$^2$; **BMI: _____ and** |
| | 3. A polysomnography (PSG) is performed within 24 months of first consultation for HGNS implant; **PSG Date: _____ and** |
| | 4. Beneficiary has predominantly obstructive events (defined as central and mixed apneas less than 25% of the total AHI); **Percent of Central and Mixed Apneas: _____ and** |
| | 5. AHI is 15 to 65 events per hour; **AHI Events per hour: _____ and** |
| | 6. Beneficiary has documentation that demonstrates CPAP failure (defined as AHI greater than 15 despite CPAP usage) or CPAP intolerance (defined as less than 4 hours per night, 5 nights per week or the CPAP has been returned) including shared decision* making that the patient was intolerant of CPAP despite consultation with a sleep expert: **CPAP failure/intolerance: _____ and** |
| | 7. Absence of complete concentric collapse (CCC) at the soft palate level as seen on a drug-induced sleep endoscopy (DISE) procedure; **CCC Absence: _____ and** |
| | 8. No other anatomical findings that would compromise performance of device (e.g., tonsil size 3 or 4 per standardized tonsillar hypertrophy grading scale). **Free of compromising anatomical findings: _____.** |

**Limitations**

The following are considered not reasonable and necessary and therefore will be denied:

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| | 1. Hypoglossal nerve neurostimulation is considered not medically reasonable and necessary for all other indications. |
| | 2. Non-FDA-approved hypoglossal nerve neurostimulation is considered not medically reasonable and necessary for the treatment of adult obstructive sleep apnea due to insufficient evidence of being safe and effective. |
| | 3. Hypoglossal nerve neurostimulation is considered not medically reasonable and necessary when any of the following contraindications are present: |
| | a) Beneficiaries with central and mixed apneas that make up more than one-quarter of the total AHI. |
| | b) Beneficiaries with an implantable device could experience unintended interaction with the HGNS implant system. |



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| | |
|---|---|
| | c) BMI equal to or greater than 35 |
| | d) Neuromuscular disease |
| | e) Hypoglossal-nerve palsy |
| | f) Severe restrictive or obstructive pulmonary disease |
| | g) Moderate-to-severe pulmonary arterial hypertension |
| | h) Severe valvular heart disease |
| | i) New York Heart Association class III or IV heart failure |
| | j) Recent myocardial infarction or severe cardiac arrhythmias (within the past 6 months) |
| | k) Persistent uncontrolled hypertension despite medication use |
| | l) 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. |
| | m) Coexisting non-respiratory sleep disorders that would confound functional sleep assessment |
| | n) Beneficiaries who are, or who plan to become pregnant. |
| | o) Beneficiaries who require Magnetic resonance imaging (MRI) with model 3024. |
| | p) Beneficiaries, who require Magnetic resonance imaging (MRI) with model 3028, can undergo MRI on the head and extremities if certain conditions and precautions are met. Please refer to the Manufacturer Guidelines for this model and future models for more information. |
| | q) Beneficiaries who are unable or do not have the necessary assistance to operate the sleep remote. |
| | r) Beneficiaries with any condition or procedure that has compromised neurological control of the upper airway. |

The patient is an appropriate surgical candidate for anesthesia.

I declare that I am certified by the FDA approved manufacturer's second opinion service of validation.

*Shared Decision Making, by definition, is any documented conversation between an attending provider and the patient, and not between multiple providers. Providers shall provide these documents if requested by this contractor.

Date: _____ Time: _____ Provider Name: _____

Provider Signature: _____


SUBMIT