NETWORK HEALTH PLAN/NETWORK HEALTH INSURANCE CORPORATION
MEDICAL POLICY DEVELOPMENT/REVIEW SUMMARY

1570 Midway Pl.
Menasha, WI 54952

Meeting: Utilization Management Committee	Date: 12/14/2023
Title/Topic: Medical Policy-Hypoglossal Nerve Stimulation	Policy Number: n05692
Purpose: Annual Review	Outcome: Accept as proposed
Line of Business: Commercial	Effective Date: 12/14/2023

INTRODUCTION:
Includes definition of problem or opportunity. Provides background information on the topic. Describes current state. May also include prior state and/or factors that have changed. Includes operational definitions where key terms may have varied interpretation.

Hypoglossal nerve stimulation (HGNS) is the use of an implanted medical device that works to reduce the occurrence of obstructive sleep apnea by electrically stimulating the hypoglossal nerve to the tongue. This stimulation activates the muscles of the tongue, increasing tone and moving it forward away from the back of the airway.

This medical policy provides guidance for Utilization Management Coordinator Registered Nurses (UMC-RN) regarding determinations involving the medical necessity of Hypoglossal Nerve Stimulation implantation. This policy is due for annual review.

ACTION RECOMMENDED:
States recommendations in specific terms. Includes a summary of what should be accomplished, methods, and timetable (if applicable). Recommendations on implementation and follow-up plans may also be included.

Annual review has been conducted and the Hypoglossal Nerve Stimulation medical policy is presented for review and approval with changes as written.

No changes were made to the intention or utilization guidance of this policy. Changes made include updating of references, grammatical updates, and verification of CPT codes.

ANALYSIS/JUSTIFICATION:
Includes information relevant to the recommended action including information used in formulation the recommendations. Information will include reference to any existing Centers for Medicare & Medicaid Services (CMS) coverage determinations as well as any existing established vendor criteria. Information may include financial/cost data, service measures, projections or other key measures or process tools, recommendations from a clinical provider with expertise regarding the topic, and/or information from other widely used treatment guidelines or peer reviewed clinical literature.

The Centers for Medicare/Medicaid (CMS) has guidance. Local Coverage Determination (LCD) Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (L38387) outlines the conditions for overage for Medicare Members.

MCG, Ambulatory Care 27th Edition –Hypoglossal Nerve Stimulation, Implantable A-0973 indicates current role remains uncertain.

REFERENCES:
Includes detailed description regarding source(s) of information used for development of policy or recommendations via citation.

- Medicare (CMS) Local Coverage Determination, Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea L38387, 04/01/2020

- MCG Ambulatory Care 27th Edition Guidelines, Hypoglossal Nerve Stimulation, Implantable AGC: A-0973(AC)

REVISION REASON:
Includes the date changes or updates were made and summary of changes applied.

12/14/2023: Annual review. References were reviewed and updated, grammatical updates completed, CPT code verification was performed to monitor for changes and/or updates.

Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.