Medical Policy
Management of Obstructive Sleep Apnea - OSA Oral Appliances

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Policy Number: 529
BCBSA Reference Number: NA

Related Policies
- Actigraphy, #533
- Bi-Level Positive Airway Pressure (BPAP) Devices, #527
- Home Apnea Monitoring, #224
- Management of Obstructive Sleep Apnea (OSA) using Auto-Titrating Positive Airway Pressure (APAP) and Continuous Positive Airway Pressure (CPAP) Devices, #526
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- Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, #130

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Indications for Oral Appliances (MRA and TRD)¹

Treatment with OA may be considered MEDICALLY NECESSARY for patients with severe OSA (apnea/hypopnea index [AHI] greater than 30) meeting at least one of the criteria (1-3) below:
1. The patient is not a candidate for positive airway pressure therapy;
   OR
2. Positive airway pressure therapy has not been effective despite a 45 day trial and participation in a positive airway pressure compliance program;
   OR
3. The patient has tried continuous positive airway pressure (CPAP) but has not been compliant despite a 45 day trial and participation in a positive airway pressure compliance program.

Treatment with OA may be considered MEDICALLY NECESSARY for patients with mild or moderate OSA meeting both of the following criteria (A and B) below:
A. At least one of the following:
   1. AHI greater than or equal to 15 and less than or equal to 30;
   OR
OR
2. AHI 5–14 with any of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, treatment-resistant hypertension, ischemic heart disease, history of stroke;

AND

B. At least one of the following:
1. The patient is not a candidate for positive airway pressure therapy;
   OR
2. Positive airway pressure therapy has not been effective despite a 45 day trial and participation in a positive airway pressure compliance program;
   OR
3. The patient has tried CPAP but has not been compliant despite a 45 day trial and participation in a positive airway pressure compliance program;
   OR
4. The patient prefers to use an OA rather than PAP as the initial therapy.

Indications for custom fabricated oral appliances (CPT E0486)
Prefabricated oral appliances may be considered NOT MEDICALLY NECESSARY therapy for obstructive sleep apnea in any clinical situation.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

A custom fabricated mandibular advancement oral appliance (E0486) used to treat obstructive sleep apnea (OSA) is covered if criteria A - D are met.

A. The beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea testing.
B. The beneficiary has a Medicare-covered sleep test that meets one of the following criteria (1 - 3):
   1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
   2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
      a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
      b. Hypertension, ischemic heart disease, or history of stroke; or
   3. If the AHI> 30 or the RDI> 30 and meets either of the following(a or b):
      a. The beneficiary is not able to tolerate a positive airway pressure (PAP) device; or,
      b. The treating physician determines that the use of a PAP device is contraindicated.
C. The device is ordered by the treating physician following review of the report of the sleep test. (The physician who provides the order for the oral appliance could be different from the one who performed the clinical evaluation in criterion A.)
D. The device is provided and billed for by a licensed dentist (DDS or DMD).

If all of these criteria (A-D) are not met, the custom fabricated oral appliance (E0486) will be denied as not reasonable and necessary.
A prefabricated oral appliance (E0485) will be denied as not reasonable and necessary. There is insufficient evidence to show that these items are effective therapy for OSA.

Custom fabricated mandibular advancement devices that have not received a written coding verification from the Pricing, Data Analysis, and Coding (PDAC) contractor will be denied as not reasonable and necessary.

**Local Coverage Determination (LCD): Oral Appliances for Obstructive Sleep Apnea (L28603)**


**Prior Authorization Information**

**Commercial Members: Managed Care (HMO and POS)**
Prior authorization is required through AIM Specialty Health.

**Commercial Members: PPO, and Indemnity**
Prior authorization is NOT required.

**Medicare Members: HMO BlueSM and PPO BlueSM**
Authorizations are required for all medically necessary services performed in the inpatient setting. Authorizations are NOT required for when these services are performed in the outpatient setting.

**CPT Codes / HCPCS Codes / ICD-9 Codes**

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>E0485</td>
<td>Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>E0486</td>
<td>Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment</td>
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</tbody>
</table>

**Description**

This policy is applicable to use of oral appliances in the management of obstructive sleep apnea (OSA). The term oral appliance (OA) includes mandibular repositioning appliances (MRA) and tongue retaining devices (TRD). This document refers to both custom-made devices (CPT E0846) and over-the-counter or prefabricated devices (CPT code E0485).
In addition to lifestyle changes, (weight loss, avoidance of alcohol and sedatives etc.) positive airway pressure (PAP) therapy is considered to be the first-line approach to the management of patients with all degrees of obstructive sleep apnea. For patients who have mild or moderate OSA, certain OAs may be used as an alternative to PAP therapy in patients who are intolerant of PAP therapy, those for whom PAP therapy is ineffective, and those who prefer to consider an OA rather than PAP as a first line therapy. It is highly recommended that the decision to use an OA in the management of OSA should follow consultation with a sleep medicine specialist. Mandibular repositioning appliances (MRA) cover the upper and lower teeth and hold the mandible in an advanced position with respect to the resting position. Tongue retaining devices (TRD) hold only the tongue in a forward position with respect to the resting position, without mandibular repositioning. Both appliances change the contour of the upper airway such that the likelihood of airway collapse during sleep is reduced.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>1/2013</td>
<td>Updated to add new CPT code 95782 and 95783.</td>
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<tr>
<td>9/1/2010</td>
<td>BCBSA National medical policy review. Changes to policy statements.</td>
</tr>
<tr>
<td>5/2009</td>
<td>Updated prior authorization information.</td>
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<tr>
<td>5/2007</td>
<td>Updated coverage and non coverage guidelines for oral appliances for sleep apnea.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References

Endnotes

1 Based on AIM Specialty Health: Sleep Disorder Management Diagnostic & Treatment Guidelines Program - October 2013.