healthfirst
Health Insurance for New Yorkers

# Reimbursement Policy

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| **Subject:** | Oral Sleep Apnea Device Appliance | | |
| **Policy Number:** | PO-RE-099v1 | | |
| **Effective Date:** | 05/01/2024 | **Last Approval Date:** | 03/18/2024 |

## I. Policy Description

Healthcare Common Procedure Coding System (HCPCS) E0485 and E0486 describe oral appliances which are used for the treatment of Obstructive Sleep Apnea (OSA). These oral appliances are sometimes referred to as Mandibular Repositioning Devices (MRD). A custom-fitted appliance is not the same as a custom fabricated appliance.

- Healthcare Common Procedure Coding System (HCPCS) code E0485 describes a prefabricated oral appliance which may or may not be adjustable and custom-fitted to the patient.
- Healthcare Common Procedure Coding System (HCPCS) code E0486 describes a custom fabricated oral appliance created from scratch using oral/dental impressions or molds taken from the patient.

Since 2006, the American Academy of Sleep Medicine (AASM) Practice Parameters have recognized oral appliances as first line treatment for mild to moderate obstructive sleep apnea (OSA), and as second line treatment for severe OSA.

The information below applies to the following lines of business.

- Child Health Plus
- Small/Individual Group (Commercial Plan)
- Essential Plan
- Medicaid Managed Care
- Medicare PPO
- Integrated Benefits Dual Connection Plan
- Health & Recovery Plan (HARP)
- Medicare Advantage
- Medicaid Advantage Plus/MAP (Complete Care)
- Qualified Health Plan (QHP)
- Managed Long Term Care Partial Capitation Plan (MLTCP)
- Senior Health Plan (SHP)- Coverage based on benefit plan.

**Reimbursement Guidelines**

1. Services Bundled into the Appliance/Device

a. Reimbursement for the appliance includes all time, labor, materials, professional services, and radiology and lab costs, necessary to provide and fit the device. It also includes all costs associated with follow up, fitting, and any adjustments during the first 90 days after provision of the oral appliance are included in the payment for device.

b. Those visits, services, and supplies may not be separately reported and will be denied as not eligible for separate reimbursement if claims are submitted.

c. Services rendered after 90 days will be denied unless medical necessity is established.

2. Billing Guidelines:

a. The following modifiers must be billed in conjunction with Healthcare Common Procedure Coding System (HCPCS) E0485 or E0486.

| Modifier | Description |
|---|---|
| **KX** | Requirements specified in the medical policy have been met (If the requirements for the KX modifier are not met, the KX modifier must not be used) |
| **NU** | New durable medical equipment purchase |

b. Please refer to Healthfirst Provider Manual for authorization requirements. *See section 10 and 12 of the provider manual for more details*.

3. General Documentation Requirements:

To support and substantiate claims for an oral sleep apnea device/appliance (E0486), the following documentation must be kept on file and supplied by the dentist (DMD, DDS) for review upon request:

a. A copy of the original physician's (MD, DO, etc.) request, order, or referral to dentist (DMD, DDS) for the oral sleep apnea appliance. (NOTE: The physician's order does not need to indicate the specific brand or type of appliance. These decisions will most often be made by the dentist.)

b. A copy of the physician's documentation that sleep study was performed and results requiring an oral sleep appliance. This can be physician's office visit notes; the actual sleep study report is not necessarily required.

c. A copy of the appliance order:
   i. The order to identify the name or description of the appliance.
   ii. The order should be signed and dated by the ordering provider.

d. If custom-fabricated appliance (E0486):
   i. Documentation that impression or mold were taken

e. At the time of delivery of the oral appliance, the dentist is responsible for providing instruction on the safe, proper and effective use and care of the oral appliance; this instruction must be documented, signed and dated in the medical record.

*This policy is not an authorization or guarantee of payment. Reimbursement is subject to member eligibility, program coverage, and medical necessity at the time the service is provided.*

## II. Applicable Codes

| Code | Description | Comment |
|---|---|---|
| E0485 | Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment | |
| E0486 | Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment | |
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## III. Definitions

| Term | Meaning |
|---|---|
| HCPCS | Healthcare Common Procedure Coding System |
| MRD | Mandibular Repositioning Devices |
| OSA | Obstructive Sleep Apnea |
| DMD | Doctor of Dental Medicine |
| DDS | Doctor of Dental Surgery |
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## IV. Related Policies

| Policy Number | Policy Description |
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| N/A | N/A |

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*Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.*

## V. Reference Materials

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| CMS.gov (Oral Appliances for Obstructive Sleep Apnea) |
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## VI. Revision History

| Revision Date | Summary of Changes |
|---|---|
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**Disclaimer**

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.