Medical Policy
Management of Obstructive Sleep Apnea (OSA) using Oral Appliances

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Policy Number: 529
BCBSA Reference Number: NA
NCD/LCD: Local Coverage Determination (LCD): Oral Appliances for Obstructive Sleep Apnea (L33611)

Related Policies
- Actigraphy, #533
- Bi-Level Positive Airway Pressure (BPAP) Devices, #527
- Home Cardiorespiratory Monitoring, #224
- Management of Obstructive Sleep Apnea (OSA) using Auto-Titrating Positive Airway Pressure (APAP) and Continuous Positive Airway Pressure (CPAP) Devices, #526
- Multiple Sleep Latency Testing - MSLT and Maintenance of Wakefulness Testing - MWT, #534
- Polysomnography and Home Sleep Testing, #525
- Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, #130

Policy¹
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Indications for Custom Fabricated Oral Appliances (HCPCS E0486)

Treatment with OA may be considered MEDICALLY NECESSARY for patients with severe OSA (apnea/hypopnea index [AHI] greater than 30) meeting both of the following criteria (A-B) below:

A. The appliance is a TRD or a MRA which complies with CMS criteria; AND
B. One of the following (a-c) applies:
   a. The patient is not a candidate for positive airway pressure therapy; or
   b. Positive airway pressure therapy has not been effective despite a 45 day trial and participation in a positive airway pressure compliance program; or
   c. 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 all of the following criteria (A-C) below:

A. At least one of the following:
   a. AHI greater than or equal to 15 and less than or equal to 30; or
   b. AHI 5–14 with any of the following: excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, treatment-resistant hypertension (persistent hypertension in a patient taking three or more antihypertensive medications), 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; AND

C. The appliance is a TRD or a MRA which complies with CMS criteria.*

Prefabricated Oral Appliances (HCPCS E0485)
Prefabricated oral appliances are considered NOT MEDICALLY NECESSARY for obstructive sleep apnea in any clinical situation.

*When MRAs are used in the management of OSA, they must comply with all of the following specifications as outlined by Centers for Medicare and Medicaid Services (CMS):

- Have a fixed mechanical hinge at the sides, front, or palate
- Have a mechanism that allows the mandible to be advanced in increments of one millimeter or less
- Be able to protrude the mandible beyond the front teeth at maximum protrusion
- Be adjustable by the beneficiary in increments of one millimeter or less
- Retain the adjustment setting when removed
- Maintain mouth position during sleep so as to prevent dislodging the device.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the link below.
Oral Appliances for Obstructive Sleep Apnea (L33611)

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

Prior Authorization Information
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.
### Outpatient

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Coverage Details</th>
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</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>The requirements of BCBSMA Sleep Management Program may require prior authorization via AIM Specialty Health. These requirements are member-specific: please verify member eligibility and requirements through AIM Specialty Health at <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a> or call 1-866-745-1783.</td>
</tr>
<tr>
<td>Commercial PPO</td>
<td>The requirements of BCBSMA Sleep Management Program may require prior authorization via AIM Specialty Health. These requirements are member-specific: please verify member eligibility and requirements through AIM Specialty Health at <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a> or call 1-866-745-1783.</td>
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**CPT Codes / HCPCS Codes / ICD Codes**

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.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<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>
</tr>
</tbody>
</table>

The following ICD Diagnosis Codes are considered medically necessary when submitted with the HCPCS codes above if medical necessity criteria are met:

**ICD-10 Diagnosis Codes**

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>G47.33</td>
<td>Obstructive sleep apnea (adult) (pediatric)</td>
</tr>
</tbody>
</table>

The following HCPCS code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:
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>
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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 code E0486) 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>5/2017</td>
<td>Prior Authorization Information clarified. 5/1/2017</td>
</tr>
<tr>
<td>1/2017</td>
<td>Clarified coding information.</td>
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<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>
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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

Specialty Society Guidelines and Systematic Reviews

Other Literature


Endnotes

1 Based on AIM Specialty Health: Sleep Disorder Management Diagnostic & Treatment Guidelines Program. Effective May 15, 2017.