

FREQUENTLY ASKED QUESTIONS

The American Academy of Dental Sleep Medicine provides support for its members in matters relating to insurance reimbursement for oral appliance therapy. The following section on Frequently Asked Questions (FAQ), developed by the Health Policy Education Committee, is designed to highlight the more commonly encountered issues that arise in the process of seeking payment. For additional information, members may submit specific questions to the AADSM staff via email at info@aadsm.org.

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1. Why is oral appliance therapy for sleep apnea covered by medical, not dental, insurance?

Oral appliance therapy is covered by medical insurance because the dentist is treating the patient for a medical condition, namely obstructive sleep apnea, and not a dental condition. The treating physician must first render the diagnosis and prescribe oral appliance therapy before the dentist can initiate therapy.

2. How does a dentist become a participating network provider in a medical insurance plan?

Some, but not all, insurance carriers will allow dentists, as durable medical equipment suppliers, to become in-network providers of oral appliance therapy to patients with obstructive sleep apnea. To become an in-network provider, the dentist should contact the insurance companies most frequently used in his or her area, inquire as to whether provider networks exist for oral appliance therapy, and request an application to participate in the insurer's provider network.

3. What is meant by the "gap exception?"

In some instances, within a specific geographical area there may not be an "in-network" provider of oral appliance therapy for patients with obstructive sleep apnea. Because of this "network gap," many insurers provide a "gap exception" to subscribers so that they may utilize an out-of-network provider. The out-of-network provider is paid at the same rate as an in-network provider.

To invoke the gap exception, the dentist providing oral appliance therapy must first submit a formal request to the insurance carrier for gap exception, as it is not immediately granted. Upon review of the request, a determination is made as to whether the gap exception is warranted. If approved, the gap exception is valid but only within a specific time frame. When seeking a gap exception, it is important that all conversations with insurance representatives be documented.

4. Are only physicians allowed to order diagnostic tests for sleep apnea? Can dentists order home sleep studies as well?

Whether or not a dentist is legally permitted to order a home sleep study depends on the scope of the practice of dentistry under state law. Each state has a statute that specifically defines the scope of dental practice. Dentists are advised to review their state statutes and/or seek legal counsel on this matter.

5. Which diagnoses support oral appliance therapy as a “reasonable and medically necessary” procedure?

Typically, obstructive sleep apnea (ICD-9-CM diagnostic code 327.23) is the diagnosis most frequently used to support oral appliance therapy. Some insurers may also cover oral appliance therapy with a diagnosis of upper airway resistance syndrome if certain comorbidities exist and the Respiratory Disturbance Index (RDI) is greater than 5. However most, if not all, insurers will not cover oral appliance therapy when the primary diagnosis is snoring.

6. When does the 10th edition of the International Classification of Diseases set of diagnostic codes (ICD-10) go into effect and will ICD-10 affect billing for oral appliance therapy?

On October 1, 2015, the ICD-9-CM code set used to report medical diagnoses and inpatient procedures will be replaced by ICD-10-CM code set. The implementation of ICD-10-CM will affect billing because the diagnostic codes used in claims submission will change. For example, ICD-9-CM diagnostic code 327.23 for obstructive sleep apnea will be replaced with code ICD-10-CM code G47.33. In general, the ICD-10-CM code set contains an additional 50,000 codes compared to the previous edition and the codes are more specific.

7. Is a written order from the treating physician required before initiating oral appliance therapy?

Dentists providing oral appliance therapy must have a written order from the treating physician on file before delivering the oral appliance to the patient and submitting the claim. Dentists may not generate the written order themselves since they are not licensed to perform and interpret sleep tests and diagnose obstructive sleep apnea. The written order (photocopy, facsimile image, electronically maintained or pen-and-ink document) for oral appliance therapy must contain:

- Beneficiary’s name
- Physician’s name, legible signature, NPI number, and signature date
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item (narrative description or brand name/model number)

8. When is preapproval from the insurance company for oral appliance therapy required and what is the difference between precertification, preauthorization and predetermination?

Preapproval requirements vary from insurer to insurer, therefore it is necessary to contact the insurer to check whether preapproval is necessary. Precertification is the process of confirming whether or not oral appliance therapy is a service covered by the insurer. Preauthorization is the process of confirming whether the insurer considers the service medically necessary for the specific patient. Predetermination is the process of confirming the amount that the insurer will reimburse for the service.

9. Is the initial examination for oral appliance therapy, including x-rays, reimbursed separately from the fabrication and delivery of the oral appliance?

Insurance coverage varies depending upon the policies of the insurance carrier. Medicare, for example, will not separately reimburse dentists for the initial examination; reimbursement is all inclusive of all time, labor, materials, professional services, radiology and laboratory costs necessary to provide and fit the oral appliance. On the other hand, many private insurers do reimburse dentists for the initial patient evaluation separately, including x-ray imaging.

10. Are office visits after delivery of the oral appliance to the patient billed separately?

Insurance coverage varies depending upon the policies of the insurance carrier. Medicare, for example, will not reimburse dentists for office visits after delivery of the oral appliance. The lump-sum payment derived from the DMEPOS Fee Schedule includes all time, labor, materials, and professional services incurred in the fabrication and fitting of the oral appliance and for any adjustments and professional services rendered during the 90 days following initial placement of the oral appliance. Some private insurers, on the other hand, do reimburse dentists for office visits after delivery of the oral appliance.

11. Which CPT codes are used to bill for office visits? What differentiates one Evaluation and Management (E/M) code from another?

Patient visits are billed using evaluation and management (E/M) codes, which are described in the CPT code book. Office visits are billed using two ranges of codes: E/M codes 99201-99205 for new patients; E/M codes 99211-99215 for established patients. The distinction between the codes primarily depends upon the level of service, extent of the physical examination, level of detail in the patient history, and the amount of time spent in consultation with the patient.

12. What are the HCPCS codes for oral appliance therapy for sleep apnea?

The two HCPCS (Healthcare Common Procedure Coding System) codes most commonly used in claims submission for oral appliance therapy for sleep apnea are:

E0485 - Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment

E0486 - Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment

The difference between the two codes is the method of fabrication. E0485 is for prefabricated items whereas E0486 is for custom-fabricated items. In most cases, insurance companies will not pay for prefabricated oral appliances. Other billable but not payable codes are A9270 for non-covered items or services, such as the tongue-retaining device, and E1399 for miscellaneous DME.

13. Which code modifiers may be used in billing for oral appliance therapy for sleep apnea?

- NU: Purchase of new and unused equipment; oral appliance is custom made for the patient
- KX: Requirements specified in the medical policy have been met
- EY: No physician order, or order by other licensed health care provider, for this item or service
- GA: Item or service expected to be denied as not reasonable and necessary; Advance Beneficiary Notice of Noncoverage (ABN) issued and on file
- GZ: Item or service expected to be denied as not reasonable and necessary; no ABN issued

Requirements for the use of modifiers vary from payer to payer.

14. Is the claim for oral appliance therapy submitted at the time of the initial appointment or after delivery of the oral appliance?

The claim for oral appliance therapy is submitted after delivery of the oral appliance.

15. Which version of the CMS 1500 claim form is currently in use and where can I find instructions on filling out the claim form?

As of April 1, 2014, Medicare no longer accepts the CMS-1500 (08-05) claim form. The National Uniform Claims Committee revised CMS-1500 (08-05) and replaced it with CMS-1500 (02-12) to accommodate International Classification of Disease, Tenth Revision (ICD-10) codes along with other changes. Instructions for completing the claim form are located in the *Medicare Claims Processing Manual, Publication 100-04, Chapter 26*.

16. What are the advantages of submitting claims electronically using Version 5010 versus manually using the CMS 1500 Form?

Claims submitted electronically are handled more efficiently and quickly, hence payment is received sooner. There are fewer claims rejected due to clerical errors if the claim is submitted electronically. Also with electronic submission, receipt of the claim is verified.

17. What documentation is required to support claims for oral appliance therapy for sleep apnea?

Although the criteria for claims submission vary from insurer to insurer, the following documentation is generally required:

- Medical record of face-to-face examination of patient by treating physician
- Diagnostic sleep study dated within the last 5 years
- Written order from treating physician for oral appliance therapy
- Dentist's clinical examination notes
- FDA 510(k) approval of oral appliance
- Proof of delivery of oral appliance to patient

The medical record must contain sufficient documentation of the patient's condition to substantiate the medical necessity for oral appliance therapy. If the information in the medical record does not adequately support the medical necessity for oral appliance therapy, the dentist may be liable for the dollar amount of the claim on assigned claims. Supporting documentation must be on file for seven years.

18. What code(s) may be used for repair of an oral appliance?

The code for repair of an oral appliance is K0739. To support such claims, the dentist must maintain detailed records describing the need, justification, and nature of all repairs.

19. What documentation is required to replace an oral appliance?

A written order from the treating physician is required to confirm medical necessity and reasonableness of replacing the oral appliance. For Medicare, oral appliances are eligible for replacement only at the end of

their five-year reasonable useful lifetime except in the case of loss, theft or irreparable damage due to accident or natural disaster.

20. What is involved in enrolling in the Medicare program as a DME supplier?

To enroll in the Medicare program, the following actions are required:

- Obtain National Provider Identifier (NPI) number
- Submit Form CMS-855S to the National Supplier Clearinghouse (NSC), which is the CMS-designated national enrollment contractor for DMEPOS suppliers.
- Submit Form CMS-460 (Participating Physician or Supplier Agreement)
- Submit Form CMS-588 (Electronic Funds Transfer Authorization Agreement)

21. In the process of enrolling in the Medicare program as DME suppliers, are dentists required to comply with all of the Medicare DMEPOS Supplier Standards or do some exemptions apply?

Dentists are required to comply with all Medicare DMEPOS Supplier Standards with two exceptions. Dentists are not required to post a surety bond and their dental practices are not required to be accredited by a CMS-approved accrediting organization.

22. Under what circumstances are dentists required to submit claims to Medicare for services rendered to Medicare beneficiaries?

All dentists, even those who are not enrolled in the Medicare program, must submit claims to Medicare for providing oral appliance therapy to Medicare beneficiaries. There are two exceptions to this rule:

- The dentist formally opts out of the Medicare program.
- The patient signs an Advance Beneficiary Notice of Noncoverage electing the option that directs the dentist not to submit his or her claim to Medicare.

23. What is the difference between opting out of the Medicare program and not enrolling in the Medicare program?

Opting out of the Medicare program is not the same as not enrolling in the Medicare program. When a provider/supplier does not enroll in the Medicare program, he or she is still obligated, for example, to submit claims to Medicare on the beneficiary's behalf. According to the *Medicare Benefit Policy Manual, Chapter 15, Section 40*:

“The only situation in which non-opt-out physicians or practitioners, or other suppliers, are not required to submit claims to Medicare for covered services is where a beneficiary or the beneficiary's legal representative refuses, of his/her own free will, to authorize the submission of a bill to Medicare.”

If the DME supplier has not enrolled in the Medicare program, he or she is required to provide the Medicare beneficiary an Advance Beneficiary Notice of Noncoverage (ABN) prior to rendering the item or service that is usually covered by Medicare. In filling out the ABN, the beneficiary indicates whether or not a claim should be submitted to Medicare. Providers and suppliers must follow the beneficiary's directive for claim submission as indicated on the ABN.

To avoid being subject to this and other Medicare rules and regulations, the provider/supplier needs to opt out of the Medicare program entirely.

When the provider/supplier opts out of the Medicare program, no services provided by the provider/supplier are covered by Medicare; therefore no payment is made by Medicare to the provider/supplier or to the beneficiary unless the beneficiary is in need of emergency or urgent care. The duration of the opt-out period is two years with an option to renew for subsequent two-year periods.

To opt out of the Medicare program, the provider/supplier must: 1) file an affidavit with Medicare specifying that he or she agrees to opt out of Medicare for a period of two years and meet certain other criteria; and 2) enter into private contracts with all Medicare beneficiaries to whom the provider/supplier renders services that otherwise would be covered by Medicare. By signing the private contract, the beneficiary agrees to give up Medicare payment for services rendered by the provider/supplier and pay the provider/supplier without regard to any limits on the amount of the charges.

Providers/suppliers who opt out of the Medicare program cannot elect to opt out of the program for some Medicare beneficiaries but not others, or for some services and not others. Only individuals may opt out of the Medicare program, not group practices and organizations.

24. Under what circumstances should the Advance Beneficiary Notice of Noncoverage be used?

The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is a standard form issued by providers / suppliers to Medicare beneficiaries stipulating that Medicare is likely to deny payment for the specific claim, and that if Medicare denies the claim, the beneficiary will be liable for the full charge of the item or service. The ABN allows the beneficiary to make an informed decision as to whether to accept an item or service for which he or she may have to pay out-of-pocket or through supplementary insurance.

Mandatory use of ABN is indicated when:

- Dentist is not enrolled in the Medicare program.
- Oral appliance is not a PDAC-approved device.
- Oral appliance therapy is not considered medically reasonable and necessary.

The ABN may also be issued voluntarily as a courtesy to the Medicare beneficiary to forewarn the beneficiary of potential financial obligation. When an ABN is issued voluntarily, the provider/supplier is not required to adhere to the issuance guidelines; namely, the beneficiary is not required to select an option or sign the document.

25. Under what circumstances can dentists collect the full amount of the charges for oral appliance therapy from the Medicare beneficiary?

If the dentist elects nonparticipating status with non-assignment of claims, he or she can collect the full amount of his or her charges directly from the Medicare beneficiary; the beneficiary, in turn, would then collect the allowed amount from Medicare as specified in the Medicare Fee Schedule.

Alternatively, the dentist can collect full charges if he or she opts out of the Medicare program and enters into a private contract with the Medicare beneficiary or if the Medicare beneficiary signs an Advance Beneficiary Notice of Noncoverage.

26. What is a National Coverage Determination (NCD)? Is oral appliance therapy for sleep apnea covered by an NCD?

National Coverage Determinations are developed by the Centers for Medicare and Medicaid Services to describe the circumstances under which the specific item or service is covered by Medicare nationwide.

National Coverage Determinations exist for polysomnography and CPAP therapy, but not for oral appliance therapy.

27. What is a Local Coverage Determination (LCD)? Where can I find the LCDs on oral appliance therapy?

In the absence of a National Coverage Determination, Medicare Administrative Contractors (MAC) are responsible for determining whether specific items and services are reasonable and medically necessary. A Local Coverage Determination (LCD) is a decision by the MAC regarding whether or not to cover a particular item or service within the MAC's regional jurisdiction.

In regards to oral appliance therapy for sleep apnea, four regional DME MACs decide the conditions for coverage within their jurisdictions. The LCDs for Oral Appliances for Obstructive Sleep Apnea can be found either on the CMS website in the Medicare Coverage Database (<http://www.cms.gov/medicare-coverage-database>) or on the respective DME MAC's website. For additional information on the regional DME MACs, see <http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/DME-MAC-Jurisdictions.html>.

28. What role does PDAC have in determining Medicare coverage and reimbursement?

In conjunction with the DME MACs, the Pricing, Data Analysis and Coding (PDAC) Contractor also performs several functions pertaining to the coding of items or services that are the subject of National and Local Coverage Determinations.

In terms of oral appliance therapy for sleep apnea, the PDAC Contractor determines which oral appliances qualify for billing under the HCPCS code E0486. PDAC-approved oral appliances are listed in the Product Classification List of the DME Coding System located on the PDAC web site at <https://www.dmepdac.com/dmecsapp/do/productsearch>.

29. What is the Stark Law and how does it pertain to oral appliance therapy for sleep apnea?

The federal physician self-referral statute, or Stark law, prohibits physicians from referring Medicare patients to certain entities for designated health services, if the physician or a member of his or her immediate family has a financial relationship with the entity. As such, a physician is prohibited from dispensing CPAP devices to his or her own Medicare or Medicaid patients. The Stark law, however, does not apply in most cases to a dentist who provides oral appliance therapy to his or her Medicare or Medicaid patients.

The distinction between physicians and dentists occurs because of the nature of the referral for the therapy. In the case of CPAP therapy, the physician makes the referral to his or her own practice with the intent of personally benefitting from the sale of the CPAP device. In the case of oral appliance therapy, the dentist does not make the referral; it is the treating physician who makes the referral. The dentist does not diagnose the medical condition, write the prescription, or refer the patient to his own practice; therefore the arrangement typically does not violate Stark law. Likewise, a physician can refer a Medicare patient to a dentist for oral appliance therapy under usual circumstances.

If, however, a dentist providing oral appliance therapy has a financial relationship with the referring sleep center, violation of the Stark law could be at issue. Likewise, if the referring physician has a financial relationship with the dental practice that delivers oral appliance therapy, Stark law may apply. A health care attorney should always be consulted in cases where potentially there may be a violation of the law.

30. What is the False Claim Act and how does it pertain to oral appliance therapy?

The False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. For example, if a physician or dentist submits a bill to Medicare for items or services known not to have been provided, the individual has violated the law. If convicted, the individual is subject to a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages sustained as a result of the act of that person.

The law includes a “qui tam” provision that allows persons not affiliated with the government to file actions on behalf of the government. Persons filing under the Act stand to receive a portion (usually about 15 to 25 percent) of any recovered damages.

The False Claims Act also covers overpayments. Overpayments under Medicare and Medicaid must be reported and returned within 60 days of discovery. Failure to timely report and return an overpayment (accidental or otherwise) exposes the provider/supplier to liability under this law.