



Manual: Reimbursement Policy

Policy Title: E0485, E0486 Oral Sleep Apnea Device/Appliance Documentation

Section: Documentation

Subsection: none

Date of Origin: 6/21/2007 Policy Number: RPM055

Last Updated: 11/6/2020 Last Reviewed: 11/18/2020

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

Reimbursement Guidelines

A. General Documentation Requirements

In order 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:

1. 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.)
2. 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.
3. A copy of the insurance preauthorization approval or preauthorization number is appreciated, but not required.
4. A copy of the appliance order.
 - a. The order should identify the name or description of the appliance.
 - b. The order should be signed and dated by the ordering provider (dentist, in this case).
 - c. "Signature" means hand written or electronically signed by the ordering provider (dentist) and dated.
5. If custom-fabricated appliance (E0486):
Documentation that impressions or molds were taken.

6. If pre-fabricated and custom-fitted (E0485):
 - A description of the item or appliance, including documentation of custom-fitting to the patient, with adjustments if necessary.
7. Proof of delivery to the patient.
 - a. If delivery to patient's home, a delivery ticket signed and dated by the patient/designee.
 - b. If provided in office setting, a confirmation of receipt form signed and dated by the patient and identifying the item/appliance.

B. Proof of Delivery (POD) Documentation

1. Moda Health follows CMS and Noridian Medicare proof of delivery documentation requirement guidelines. Proof of delivery is needed for any tangible supply or item which is not a professional service. This includes but is not limited to: DME, supplies, self-administered drugs, home infusion therapy supplies, orthotics, etc.
2. Methods of Delivery
 - a. Delivery directly to the member/patient or authorized representative (includes patient pick-up at the office).
 - b. Delivery via shipping or delivery service.
 - c. Delivery of items to a nursing facility on behalf of the member/patient.
3. Proof of delivery (POD) is a Supplier Standard. Suppliers are required to maintain proof of delivery documentation in their files, and to provide the documentation upon request. "POD documentation, as well as claims documentation, must be maintained in the supplier's files for 7 years (starting from the date of service)." (Noridian Medicare⁴, CMS¹³)
4. Proof of delivery documentation provides verification that the provider properly coded the item(s), that the item(s) delivered are the same item(s) submitted on the claim for reimbursement and that the item(s) are intended for, and received by, a specific member. The documentation should always include:
 - a. A sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description). The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered. (Noridian Medicare⁴)
 - b. A dated signature of the member or designee indicating receipt or delivery of the item.
 - c. Indication of the method of delivery.
 - d. If delivered to a nursing facility, POD must also include documentation from the nursing facility demonstrating receipt and/or usage of the item(s) by the member.

5. The date of service on the claim must match the date on the proof of delivery.
 - a. For delivery directly to the patient or designee, the date of service is the date of the member's signature for receipt.
 - b. For delivery via shipping or delivery service, the date of service is the date of shipment.
 - c. For delivery of items to a nursing facility (not using a shipping service), the date of service is the date of the staff's signature for receipt on behalf of the member.

C. Signature Requirements

Moda Health follows CMS and Noridian Medicare signature requirement guidelines.

1. All services provided to beneficiaries are expected to be documented in the medical records at the time they are rendered.
2. All medical record entries must include (among other things) the date of service, and a legible, dated, and timed signature of the provider. (Novitas Solutions¹⁴)
3. Providers should not add late signatures to the medical record, other than those that result from the short delay that occurs during the transcription process.
4. If the signature is illegible, providers may submit a signature log or attestation to support the identity of the signer.
5. If your facility doesn't have a signature log currently in place, Moda Health will accept all submitted signature logs regardless of the date they were created.
6. If the signature is missing, use the signature attestation process. (CMS³) The attestation must be signed and dated by the author of the medical record entry and contain sufficient information to identify the member and the specific encounter record involved.
7. For examples of specific signature situations which do and do not meet the signature requirements, refer to the chart provided by Noridian (⁷).

(Noridian Medicare⁷, Noridian Medicare², CMS³, Novitas Solutions¹⁴)

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
AASM	=	American Academy of Sleep Medicine
CMS	=	Centers for Medicare and Medicaid Services
E/M	=	Evaluation and management (service)
EOCCO	=	Eastern Oregon Coordinated Care Organization
MRD	=	Mandibular Repositioning Devices

Acronym		Definition
OSA	=	Obstructive Sleep Apnea
POD	=	Proof of Delivery

Procedure codes (CPT & HCPCS):

Code	Code Description
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

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

“POD documentation, as well as claims documentation, must be maintained in the supplier's files for 7 years (starting from the date of service).” (Noridian⁴, CMS¹³)

“The supplier should also have on file any documentation containing a description of the item delivered to the beneficiary to determine the accuracy of claims coding including, but not limited to, a voucher, invoice or statement in the supplier records. There must be a sufficient level of detail in the item description to definitively determine the appropriate HCPCS to be appended to the claim. The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the Office of Inspector General (OIG) or the National Supplier Clearinghouse for investigation and/or imposition of sanctions.” (Noridian⁴, CMS¹³)

“The medical record chronologically documents the care of the patient in order to...facilitate claims review and payment...and...serve as a legal document to verify the care provided.” (CPT Assistant⁹)

“The medical record should be complete and legible.” (CPT Assistant⁸)

“Because payers have a contractual obligation to enrollees, they may request additional documentation to validate that services provided were:

- appropriate to the treatment of the patient's condition;
- medically necessary for the diagnosis and/or treatment of an illness or injury; and
- coded correctly.” (CPT Assistant⁹)

Cross References

“Medical Records Documentation Standards.” Moda Health Reimbursement Policy Manual, RPM039.

References & Resources

1. Noridian Medicare. “Signature Requirement Questions and Answers.” Updated February 2015. Last accessed January 7, 2016. <https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirement-q-a> .
2. Noridian Medicare. “Signature Requirements.” Last accessed May 18, 2017. < <https://med.noridianmedicare.com/web/jeb/cert-reviews/signature-requirements>> .
3. CMS. “Signature Attestation Statement.” *Medicare Program Integrity Manual*. Publication 100-08, chapter 3, § 3.3.2.4.C.
4. Noridian Medicare. “Proof of Delivery.” Last accessed September 27, 2017. <https://med.noridianmedicare.com/web/jddme/topics/documentation/proof-of-delivery> .
5. Noridian Medicare. “Avoiding CERT denials for Proof of Delivery.” Last accessed 8/22/2017. <https://med.noridianmedicare.com/web/jddme/avoiding-cert-denials-for-proof-of-delivery> .
6. Noridian Medicare. “Proof of Delivery - Requirements for Signature and Date.” Last accessed 8/22/2017. <https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/proof-of-delivery-requirements-for-signature-and-date> .
7. “Documentation Guidelines for Medicare Services.” *Noridian Medicare*. September 15, 2013. May 18, 2017 < <https://med.noridianmedicare.com/web/jeb/cert-reviews/mr/documentation-guidelines-for-medicare-services> >
8. American Medical Association. “Instructions for Use of the CPT Codebook.” *Current Procedural Terminology (CPT), Introduction*. Chicago: AMA Press.
9. American Medical Association. “Coding Clarification: Principles of Documentation”, *CPT Assistant*, Summer 1992, page 21.
10. American Academy of Sleep Medicine (AASM). Practice parameters for the treatment of snoring and obstructive sleep apnea with oral appliances: an update for 2005. Available at www.aasmet.org. February 2006.

11. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. LCD for Oral Appliances for OSA (L28601, L28603, L28606, L28620). Revision effective date 9/1/2011.
12. ResMed. "Mandibular Repositioning Devices (MRD) Used for Treatment of OSA." Last accessed 10/19/2017.
https://www.resmed.com/us/dam/documents/products/dental/Narval-CC/info-sheet/1015534r2_mrd-reimbursement-sleep-lab-info-sheet_amer_eng.pdf .
13. CMS. "Proof of Delivery Documentation Requirements." *MLN Matters*, SE19003, January 17, 2019. < <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19003.pdf>>.
14. "Documentation Guidelines." *Novitas Solutions*. September 10, 2017. November 6, 2020
<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00144726> .

Background Information

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). (ResMed¹²) A custom-fitted appliance is not the same as a custom fabricated appliance.

- HCPCS code E0485 describes a prefabricated oral appliance which may or may not be adjustable and custom-fitted to the patient.
- 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. (AASM¹⁰)

Medicare approved oral appliances for treatment of obstructive sleep apnea (OSA) effective January 3, 2011, when criteria are met. (CMS¹¹)

Oral appliances for OSA or mandibular repositioning devices are most commonly billed by a licensed dentist. Medicare will only authorize a licensed dentist to bill for the MRD (E0486).

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other

professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.