moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM055
Policy Title:	E0485, E0486 Oral Sleep Apnea Device/Appliance Documentation & Bundled Services		
Section:	Documentation	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	6/21/2007	Initially Published:	11/8/2017
Last Updated:	2/2/2023	Last Reviewed:	10/11/2023
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:	2/8/2023		

Reimbursement Guidelines

A. Services Bundled into the Appliance/Device

1. 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 considered to be included in the payment for device.
2. Those visits, services and supplies may not be separately reported and will be denied as not eligible for separate reimbursement if claims are submitted.

B. 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 handwritten or electronically signed by the ordering provider (dentist) and dated.
5. If custom-fabricated appliance (E0486):
   Documentation that impressions, scans, or molds were taken.
6. If prefabricated 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.

C. 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 Medicare[4], CMS[13])

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 Medicare[4])

    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.

D. 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 Solutions[14])

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. (CMS[3]) 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 Medicare[7], Noridian Medicare[2], CMS[3], Novitas Solutions[14])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AASM	=	American Academy of Sleep Medicine
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MRD	=	Mandibular Repositioning Devices
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
OSA	=	Obstructive Sleep Apnea
POD	=	Proof of Delivery
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

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)." (Noridian[4], CMS[13])

"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." (Noridian[4], CMS[13])

"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 Assistant*[9])

"The medical record should be complete and legible." (*CPT Assistant*[8])

"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 Assistant*[9])

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). (ResMed[12]) 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, scans, 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. (AASM[10])

Medicare approved oral appliances for treatment of obstructive sleep apnea (OSA) effective January 3, 2011, when criteria are met. (CMS[11])

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 this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to 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] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
10/11/2023	Annual review; no updates.
2/8/2023	Clarification/Update: Section B.5 & Background Information: "…impressions or molds…" updated to "…impressions, scans, or molds…" for clarity per provider suggestion. Formatting fix of section B numbering.
11/9/2022	Clarification/Update: Document Title: "Bundled Services" added. Section A: New wording added about E/M services & bundled services, for clarification per discussion with Provider Networking. Cross References: Hyperlink added.
9/14/2022	Formatting/Update: Change to new header. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).

Date	Summary of Update
11/8/2017	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
6/21/2007	Original Effective Date (with or without formal documentation). Policy based on CMS documentation requirements for DME proof of delivery & CMS signature requirements.