

American Academy of Dental Sleep Medicine

# Reimbursement Guide for Oral Appliance Therapy for Obstructive Sleep Apnea



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# Introduction

## DENTAL SLEEP MEDICINE

Dental sleep medicine is the area of practice that focuses on the management of sleep-related breathing disorders, including snoring and obstructive sleep apnea, through the use of oral appliance therapy.

Oral appliance therapy involves the fabrication and fitting of a custom-made oral appliance that is worn at night to reposition the lower jaw and tongue forward to improve upper airway patency during sleep. Many types of oral appliances exist with different design features. The most common type of oral appliance for the treatment of obstructive sleep apnea is the mandibular advancement device or splint.

Since sleep-related breathing disorders are medical conditions, only medical or osteopathic physicians, preferably board certified in sleep medicine, can render the diagnosis. Thus, for obstructive sleep apnea, the diagnosis can only be made by the physician and, if prescribed, oral appliance therapy is provided by dentists trained in dental sleep medicine and in the use of oral appliances for the management of obstructive sleep apnea. Oral appliance therapy requires that the physician and dentist function as an integrated team. Treatment is enhanced if dentists and physicians work closely together to optimize therapeutic response and patient compliance.

## PURPOSE OF REIMBURSEMENT GUIDE

The purpose of this reimbursement guide is to educate dental professionals and their administrative staff on the process of obtaining payments from private and public insurers for oral appliance therapy. Since obstructive sleep apnea is a medical condition for which the physician renders the diagnosis and prescribes therapy, claims must be submitted to medical, not dental insurers. To complicate matters further, for purposes of claims submission, oral appliance therapy is categorized by Medicare and some other payers as a durable medical equipment (DME) benefit, rather than a medical service.

This reimbursement guide presents an overview of the various types of third-party payers. Both private and public insurance plans are profiled. The information on government-sponsored insurance plans is specific to the Medicare program. Additionally, the text includes basic billing and coding information, office protocols for submitting claims as well as procedures for appealing decisions if claims are denied.

This reimbursement guide presents a generalized discussion on how most private insurance companies reimburse health care professionals for services rendered. However, each insurance company is different. To facilitate the reimbursement process, dental

professionals are advised to develop relationships with key contacts at each insurance company and document in writing the procedures and coding specific to each private insurer. Since coverage policies vary among private insurers, dentists should work with each patient to determine the patient's specific plan benefits prior to providing the service in question.

Throughout the text, certain words are printed in **bold** to indicate terms that are defined in the Glossary Section. For additional information, the Resources Section contains website links, Medicare documents and templates of sample letters and attestations that may prove useful in obtaining reimbursements.

### **Disclaimer**

*The information in this reimbursement guide is intended to serve as general background information only; it is not a legal document. Prior to implementing or relying on any advice in this guide, readers should consult with their legal and financial advisors. The information contained in this document is current as of the date of publication and is subject to change.*

*Although every reasonable effort has been made to assure the accuracy of the information in this guide, the ultimate responsibility for accurate claims submission lies with the service provider. The AADSM makes no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results and consequences of use of this guide.*

## Overview of Insurance Plans

Health insurance in the United States is provided through private and public health insurance plans. Private health insurance is purchased individually or through an employer-sponsored plan. Public health insurance is provided through entitlement programs funded by the federal and state governments.

### Private Health Insurance

- Traditional Indemnity Plans, also known as Fee-For-Service Plans
- Managed Care Plans (PPO, POS, HMO)

Public Health Insurance (Medicare, Medicaid, TRICARE, CHIP): For purposes of discussion of oral appliance therapy, this document will focus on Part B of the Medicare Program.

## TRADITIONAL INDEMNITY PLANS

Medical indemnity insurance is a type of health insurance plan in which the insurance carrier reimburses the covered party regardless of where or with whom the covered party seeks health care services.

The **indemnity plan** is an agreement between the covered party and the insurance company whereby coverage is provided for the covered party based upon the stipulations of the policy. Indemnity plans may have different coverage policies for each plan beneficiary. Therefore, it is important to note that while one patient may be covered for oral appliance therapy, another patient with the same insurer may not have the same coverage.

While indemnity insurance plans offer plan beneficiaries maximum flexibility in choosing which doctor to visit, there are limitations as to the amount of the reimbursements for the covered services. Medical expense reimbursement amounts can range from a per-day cost or set percentage of the actual charges to the actual costs of the medical expenses.

Benefit amounts are determined using one of three formulas: actual charges, percentage of actual charges or indemnity.

- A medical indemnity insurance plan with actual charge benefits pays the actual amount of charges that the patient incurs for covered services. There is no limit on the amount of the expense; as long as the patient has a receipt for the service performed, the patient will receive a reimbursement for the cost of the medical expense.

- Under a medical indemnity insurance plan that pays a percentage of actual charges, the patient is responsible for the difference between the medical expense and the amount paid by the insurance company. The percentage is typically a set amount, such as 80%. Thus, if the percentage of actual charges is 80% and the medical expense is \$100, then the insurance plan covers \$80, and the patient pays the remainder, \$20 (or 20 % of the actual charges). The patient is responsible for any unpaid **deductible** and **coinsurance**.
- Under a medical indemnity insurance plan that reimburses by indemnity, the insurer pays a set amount per day of coverage. Instead of basing the reimbursement on the amount of the medical expense, the reimbursement is a set daily rate of coverage. However, if the daily rate exceeds the amount of the medical expense, the insurer only pays the amount of the medical expense.

When seeking reimbursement under the indemnity plan:

- The patient receives a statement from the dental professional for services provided and is responsible for the payment.
- The patient then submits a **claim** to the insurance company. (The dental professional may choose to help the patient file the claim.)
- The insurance company then reimburses the patient directly.

From a practical standpoint, not all patients will proceed with an oral appliance unless they know that their insurance will cover all or part of the cost. Through the process of **pre-authorization** or **pre-determination**, the dental professional may be able to confirm the patient’s anticipated insurance coverage prior to providing service. (See Office Protocols for Reimbursement).

## MANAGED CARE PLANS

The term “**managed care plans**” refers to insurance carriers that have contracted with a group of health care providers to provide care at a discounted rate for the patients enrolled in their plan. Dental professionals are eligible to become preferred (in-network) providers for insurance carriers. For the insurance plan to include coverage for oral appliance therapy, the insurance company would need to contract with dental professionals, generally as durable medical equipment (DME) providers, to provide the service at a discounted rate.

Some of the advantages of becoming an in-network provider in a managed care plan include:

- Increased patient volume;
- Ease of claim filing;
- Facilitates payment of claims (though it is not a guarantee); and
- Lays the groundwork for a smoother patient referral process.

By becoming a preferred provider, dentists alleviate some of the obstacles encountered by patients when referred by a physician to a dental professional for oral appliance therapy.

### **In-Network and Out-of-Network Providers**

Patients generally prefer to visit health care professionals who are **in-network** because services provided by in-network providers will be covered under the insurance plan whereas services provided by **out-of-network** providers may not be covered or may only be partially reimbursed. One of the difficulties for dentists in becoming in-network providers is that most insurance companies have not implemented provider networks for oral appliance therapy. Notwithstanding this challenge, dental professionals may choose to become in-network providers with the frequently used insurance companies in their area. Every effort should be made to familiarize the insurance company with the role of oral appliance therapy in the medical treatment of obstructive sleep apnea. To this end, the dental professional may consider sharing the AADSM protocols and AASM practice parameters with the insurance company to emphasize that oral appliance therapy is an accepted treatment for this medical condition.

### **Gap Waivers**

In-network benefits can sometimes also be obtained through a **gap waiver**. If a referring physician requests that his or her patient be sent to an in-network dental professional for oral appliance therapy and there is no in-network provider for this service, a gap waiver may be approved. A gap waiver allows the services of an out-of-network dental professional to be covered as an in-network benefit for the service provided. Gap waivers can be requested at any time that the plan has no qualified in-network provider. However, if the insurance plan has in-network oral surgeons who can provide oral appliance therapy, a gap waiver may not always be approved for other dental professionals.

### **Contracting with Managed Care Plan**

The following questions should be considered when contracting with a managed care plan:

- How long does it take to get paid once a claim is filed?

- Must services be pre-authorized to be paid?
- What is the turnaround time for pre-authorization?
- What does the fee include?
- Can evaluations and follow-up visits be billed separately?

Contracting is a negotiation that establishes a binding agreement. In entering into a contractual arrangement, advice from legal counsel should be sought. Fees for services can be negotiated, as can the terms of the contract.

Some managed care plans will only contract with physicians and oral surgeons, in which case dental professionals may not be included in the provider networks. Typically, managed care plans exclude dentists who provide oral appliance therapy from their provider networks because of a lack of understanding about the role of oral appliance therapy in the medical treatment of obstructive sleep apnea. Therefore, it is incumbent on the dentist to contact the medical director, a provider services representative and/or the credentialing/contracting supervisor of the insurance company to educate them accordingly.

### **Develop Relationship with Contact Person**

Dental professionals should consider developing a relationship with a specific contact person at the insurance companies at which they are likely to submit claims. A contact person can be helpful in resolving any difficulties with claims or other issues related to insurance reimbursement.

At times, it may be difficult to find the appropriate contact person. By monitoring written responses from each insurance company, the dental professional may be able to identify claim supervisors, medical policy or utilization review personnel, and medical directors. Tracking correspondence often helps in developing a list of contact persons at each of the insurance companies along with their direct mailing address, department, telephone and fax number. It may also be beneficial to reach out to the contact person by phone to further develop the relationship. Also, dental professionals and their staff are advised to develop contacts with more than one person at each company since promotions and transfers occur frequently.

## **MEDICARE PROGRAM**

### **Overview of the Medicare Program**

Medicare is a federally funded government health insurance program administered by the Centers for Medicare and Medicaid Services (CMS), which is a branch of the U.S.



Department of Health and Human Services. Enacted into law by Congress in 1965 as Title XVIII of the Social Security Act, the Medicare program provides health insurance coverage for Americans 65 years of age and older and for certain individuals who are disabled or diagnosed with end-stage renal disease.

The Medicare program consists of 4 different plans: Part A (hospital insurance), Part B (supplemental medical insurance, which broadly covers physicians' services, outpatient procedures, home health care, preventive services, and medical supplies and equipment), Part C (Medicare Advantage Plan), and Part D (prescription drug benefit).

The Medicare program is administered on the local level by independent contractors, usually private insurance companies, called **Medicare Administrative Contractors** (MACs). Previously known as fiscal intermediaries or carriers, MACs serve as the primary point of contact and chief source of information for Medicare providers on issues regarding enrollment, coverage, billing and claims appeals. MACs are also responsible for answering inquiries from Medicare beneficiaries in their local region or jurisdiction.

Initially, **Part B** local carriers reviewed all claims submitted within their respective jurisdictions, making no distinction between claims for medical / surgical services and claims for items / services known as durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). This claims review process, however, proved to be inefficient since DMEPOS claims, representing only about 5% of each carrier's workload, were often complex and time-consuming to process. It was difficult for local carriers to allocate sufficient administrative resources to the review of such a small percentage of claims.

Hence, to streamline claims processing and address other problems unique to DMEPOS claims, a new organizational structure was created in 1993 whereby review of DMEPOS claims was limited to only four regional carriers, known as DME regional carriers. The DME regional carriers were specifically established to standardize coverage and payment of DMEPOS claims exclusively.

Thus, Part B of the Medicare program became bifurcated into two broad divisions – the medical / surgical services category, which is currently administered by 12 A/B MACs, and the DMEPOS benefit category, which is administered exclusively by 4 regional DMEPOS MACs. With separation of Part B into two parts, the pricing of items and services also evolved along two different and distinct paths. In the former category, payment is based on the Physician Fee Schedule, whereas in the latter category, payment is based on the DMEPOS Fee Schedule.

Oral appliance therapy for the treatment of obstructive sleep apnea is covered by Part B of the Medicare program under the DMEPOS benefit category.

## Part B DMEPOS Benefit

In order for a DMEPOS item or service to qualify for reimbursement, it must fall into one of the following benefit categories specified in the Social Security Act (§1861(s)):

1. Durable medical equipment (DME)
2. Prosthetic devices
3. Leg, arm, back and neck braces (orthoses) and artificial leg, arm and eyes (prostheses)
4. Home dialysis supplies and equipment
5. Surgical dressings
6. Immunosuppressive drugs
7. Erythropoietin for home dialysis patients
8. Therapeutic shoes for diabetics
9. Oral anticancer drugs
10. Oral antiemetic drugs (replacement for intravenous antiemetics)
11. Intravenous immune globulin

Oral appliance therapy, for purposes of Medicare coverage, is categorized as durable medical equipment.

The term “**durable medical equipment**” is defined in section 1861(n) of the Social Security Act as equipment furnished by a DMEPOS supplier that is

- Able to withstand repeated use;
- Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years;
- Primarily and customarily used to serve a medical purpose;

- Generally not useful to an individual in the absence of an illness or injury; and
- Appropriate for use in the home.

All requirements of this definition must be met before an item can be considered durable medical equipment. Additionally, to qualify for reimbursement the equipment must be necessary and reasonable for the treatment of the patient's illness and comply with all other statutory and regulatory requirements.

Thus, all claims for oral appliance therapy reimbursement are reviewed by the DMEPOS MACs. To qualify for reimbursement, the oral appliance itself must fulfill all criteria specified in the durable medical equipment definition; oral appliance therapy must be necessary and reasonable for the treatment of obstructive sleep apnea; and all other billing, coding and documentation requirements must be met.

Reimbursement for the oral appliance itself, as well as all services related to providing therapy within a certain timeframe, is bundled into one lump-sum payment which is specified in the DMEPOS Fee Schedule. However, at the time of this writing, the fee for oral appliance therapy has yet to be published.

## **Enrollment Process**

In order to qualify for Medicare reimbursement for oral appliance therapy for obstructive sleep apnea, the dentist must enroll in the Medicare program as a **DMEPOS supplier**.

### **NPI Enrollment**

Prior to enrolling in the Medicare program, CMS first requires that providers and suppliers obtain a **National Provider Identifier (NPI)** number. The NPI is the unique identification number assigned to health care providers by the National Plan and Provider Enumeration System. Applying for the NPI is a process separate from Medicare enrollment. For more information on NPI enumeration, visit <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. Applications for an NPI are available at <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>.

### **Medicare Enrollment: Form CMS-855S**

Once an NPI is obtained, dental professionals may then enroll in the Medicare program by submitting Form CMS-855S to the National Supplier Clearinghouse (NSC), which is the CMS-designated national enrollment contractor for DMEPOS suppliers. To obtain and retain billing privileges, suppliers must be in compliance with the DMEPOS Supplier Standards (See Resources Section).

As stated in the Supplier Standards, DMEPOS suppliers are required to be accredited by a CMS-approved accreditation organization and fulfill surety bond requirements prior to submitting their applications. Beginning in late 2018, dentists are no longer exempt from the DME surety bond requirements. Dentists must obtain a surety bond with a coverage minimum of \$50,000 per practice location. Applicable bond paperwork must be sent to the NSC.

It is important to note that the accreditation of Medicare DMEPOS suppliers is entirely separate and distinct from the American Academy of Dental Sleep Medicine (AADSM) Dental Sleep Medicine Facility Accreditation. Accreditation of a Dental Sleep Medicine Facility through the AADSM is a voluntary process designed to recognize high standards of proficiency, practice and professionalism in the delivery of care to patients with sleep-related breathing disorders. Thus, although two sets of accreditation standards exist, neither accreditation as a Medicare DME supplier nor accreditation as an AADSM Dental Sleep Medicine Facility is currently a condition to practicing dental sleep medicine or receiving payment for oral appliance therapy.

The primary function of the NSC is to process DMEPOS supplier enrollment applications and ensure that only qualified suppliers are enrolled in the Medicare program. If the enrollment application is approved, the NSC assigns the qualified supplier a unique Medicare identification number. Medicare only covers durable medical equipment provided by suppliers enrolled in the Medicare Program who have a Medicare supplier number.

Once billing privileges are granted, DMEPOS suppliers are required to renew their application for billing privileges every 3 years thereafter. For additional information on the enrollment process, visit [www.palmettogba.com/nsc](http://www.palmettogba.com/nsc) and <http://www.cms.gov/MedicareproviderSupenroll>.

### **Medicare Participating Physician or Supplier Agreement: Form CMS-460**

As part of the enrollment process, dental professionals have the option of enrolling as either a “**participating**” or “**non-participating**” supplier in the Medicare program. The decision to elect participating versus non-participating status does not affect the provision of health care to Medicare beneficiaries; rather it only affects the amount of the reimbursement and source of the payments. Medicare limits the amount that it will pay for services, supplies and medical equipment. The Medicare-allowed or approved amount is the amount that Medicare determines to be the maximum amount allowable for the covered item or service.

In signing the Medicare Participating Physician or Supplier Agreement (Form CMS-460), the “participating” supplier agrees to always accept assignment of the Medicare payment, meaning that the supplier accepts the Medicare-approved amount as full payment for items or services rendered. The supplier may not bill the Medicare beneficiary in excess of the Medicare-approved amount.

Additionally, because claims are assigned, Medicare issues its payments directly to the participating supplier, not to the Medicare beneficiary. Thus, participating suppliers receive 100% of the Medicare-approved amount split between payments from Medicare and the patient. Medicare pays 80% of the Medicare-approved amount while the patient pays any unmet deductible and 20% coinsurance.

DMEPOS suppliers enrolled in the Medicare program do not have to sign the participation contract in order to bill Medicare and receive payment. However, there is a 5% reduction in the Medicare-approved amount if the supplier does not participate. Moreover, unlike participating suppliers who always accept assignment, non-participating suppliers have the option to accept or not accept assignment or they may elect to accept assignment on a case-by-case basis. For assigned claims, the Medicare payment is sent to the supplier; for the unassigned claim, the Medicare payment is sent to the Medicare beneficiary.

Thus, for non-participating suppliers who accept assignment, the non-participating supplier receives 95% of the Medicare-approved amount split between payments from Medicare and the patient. Medicare pays 80% of the discounted Medicare-approved amount (less unmet deductible) while the patient pays any unmet deductible and the 20% coinsurance.

For non-participating suppliers who do not accept assignment, however, there is no limit to the amount that the supplier may charge the Medicare beneficiary. The supplier submits the claim to Medicare on the patient's behalf. Medicare reimburses the patient, not the supplier, 80% of the discounted Medicare-approved amount (less unmet deductible). And, the Medicare beneficiary is ultimately responsible for paying the supplier the full amount of the charges.

Thus, the major benefit of Medicare participation is that Medicare payments are issued directly and in a timely manner to the participating supplier; the major drawback is that reimbursement is limited to the Medicare-approved amount. Conversely, non-participating, non-assignment suppliers rely solely upon Medicare beneficiaries for payment, but there is no limit to the amount that the supplier may charge. For more information on the Medicare Participating Physician or Supplier Agreement, visit <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf>.

### ***Electronic Funds Transfer Authorization Agreement: Form CMS-588***

The EFT authorization agreement is a form of direct deposit that allows the transfer of Medicare payments directly from a Medicare contractor's bank to the supplier's bank account. CMS requires that all providers and suppliers enrolling in the Medicare program or changing existing enrollment information use EFT. The EFT authorization agreement form may be downloaded from the CMS website at

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS588.pdf>

## COVERAGE POLICY

The primary authority for all coverage provisions and subsequent policies is the Social Security Act. Medicare Administrative Contractors (MACs) use national and/or local medical policies to apply the provisions of this Act and determine coverage.

National medical policies are developed by the Centers for Medicare and Medicaid Services (CMS) in the form of **National Coverage Determinations** and interpretative manuals. National Coverage Determinations (NCD) specify the circumstances for Medicare coverage nationwide under which certain items, services, procedures or technologies are deemed reasonable and necessary under §1862(a) (1) (A) of the Social Security Act. The coverage provisions in the interpretive manuals further define when and under what circumstances services are or are not covered.

In the absence of an NCD, Medicare Administrative Contractors are responsible for determining whether services are reasonable and necessary. Thus, local medical policies are developed by MACs, who have the authority and responsibility to establish local policy when there is no national policy on a subject or when there is a need to further define national policy. Local medical policies consist of two separate, though closely related, documents: **Local Coverage Determinations** and Policy Articles.

A Local Coverage Determination (LCD) is a decision by a Medicare Administrative Contractor regarding whether to cover a particular item or service on a contractor-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (determination as to whether the item or service is reasonable and necessary). LCDs primarily contain “reasonable and necessary” information.

LCDs are administrative and educational tools designed to assist suppliers in submitting correct claims for payment. The LCDs outline how contractors will review claims to ensure that Medicare coverage and coding requirements are met. Other information that the contractor may seek to convey to suppliers is communicated through Policy Articles.

Thus, to qualify for coverage, the item or service provided must be reasonable and medically necessary and in compliance with all Medicare coverage, coding, and billing requirements as set forth in the International Classification of Diseases-10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM), Current Procedural Terminology-4<sup>th</sup> edition (CPT-4), and Healthcare Common Procedure Coding System (HCPCS) coding guidelines as well as in the NCDs, interpretative manuals, LCDs and Policy Articles.

The MACs will deny an item or service if it does not meet any of the following conditions:

- Item or service is not reasonable and necessary under §1862(a) (1) (A) of the Social Security Act.
- Item or service does not fall into a Medicare benefit category.
- Item or service is statutorily excluded on grounds other than §1862(a) (1) (A) of the Act.
- Item or service does not meet other Medicare program requirements for payment.

With respect to oral appliance therapy for obstructive sleep apnea, there is no National Coverage Determination. Thus, the coverage determination is based solely on local medical policies developed jointly by the Medical Directors of all four DMEPOS MACs. The local medical policy for oral appliance therapy is identical in all DME MAC jurisdictions. To qualify for reimbursement, oral appliance therapy must be in compliance with the provisions set forth in the Local Coverage Determinations and related Policy Articles which can be found on each DME MAC's website or in the Medicare Coverage Database located on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareCvrgeDatabase\\_ICN901346.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareCvrgeDatabase_ICN901346.pdf).

### **DME MAC Jurisdictions**

Part B of the Medicare program pertaining exclusively to the DMEPOS benefit is administered by four regional **DME Medicare Administrative Contractors** (DME MACs). For purposes of claims review and reimbursement, Medicare claims must be submitted to the DME MAC that serves the state or territory where the Medicare beneficiary permanently resides.

Below is a list of the DME MACs and the states and territories that they service.

#### **Jurisdiction A DME MAC**

Administered by [Noridian Administrative Services](https://www.noridianmedicare.com/)  
<https://www.noridianmedicare.com/>

Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont

### **Jurisdiction B DME MAC**

Administered by [CGS Administrators](#)

<https://www.cgsmedicare.com/>

Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin

### **Jurisdiction C DME MAC**

Administered by [CGS Administrators](#)

<https://www.cgsmedicare.com/>

Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia and U.S. Virgin Islands

### **Jurisdiction D DME MAC**

Administered by [Noridian Administrative Services](#)

<https://www.noridianmedicare.com/>

Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington and Wyoming

### **Pricing, Data Analysis and Coding (PDAC) Contractor**

In conjunction with the DME MACs, the Pricing, Data Analysis and Coding (PDAC) Contractor performs several functions pertaining to the coding of items or services that are the subject of National and Local Coverage Determinations. The PDAC Contractor either creates a new HCPCS code for the specific DMEPOS item or service or assigns the individual item or service to an existing HCPCS code for the purpose of billing Medicare.

To determine the appropriate HCPCS code for the DMEPOS item or service, the PDAC Contractor reviews the product literature, specifications, and measurements and evaluates the product in the context of established policy published in the LCDs, Policy Articles and other Advisory Articles. For certain products, manufacturers or distributors are required to submit their product to the PDAC Contractor for coding verification review to determine whether the product qualifies for inclusion in the HCPCS code.

In terms of oral appliance therapy, custom-fabricated oral appliances used for the treatment of obstructive sleep apnea fall into the durable medical equipment statutory



benefit category and have been assigned the HCPCS code E0486. Code E0486 describes an oral appliance that is uniquely made for a specific patient. The procedure for making the oral appliance involves taking an impression of the patient's teeth, making a positive model of plaster, selecting an appropriate oral appliance for the specific patient, and sending the plaster cast to a licensed dental laboratory for custom fabrication. The only oral appliances that may be billed using code E0486 are those that have undergone coding verification review by the PDAC Contractor and are listed in the Product Classification List of the DME Coding System located on the PDAC web site at <https://www.dmepac.com>.

Once the custom-fabricated oral appliance comes back from the laboratory, the dentist fits the patient and makes necessary adjustments based on clinical and/or laboratory titration.

### **Coding Guidelines**

The Local Coverage Determinations (LCDs) for Oral Appliances for Obstructive Sleep Apnea (L28601; L28603; L28606; L28620) have been combined into LCD L33611, with an effective date of 10/01/2015 and a revision effective date of 01/01/2017. In setting forth the conditions for Medicare coverage, the LCDs state that the Medicare program will pay for the oral appliance only if the patient has a positive diagnosis of obstructive sleep apnea as determined by a Medicare-covered sleep test.

Specifically,

“A custom fabricated mandibular advancement oral appliance (E0486) used to treat obstructive sleep apnea (OSA) is covered if criteria A - D are met.

- A. The beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea testing.
- B. The beneficiary has a Medicare-covered sleep test that meets one of the following criteria (1 - 3):
  1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
  2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
    - a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
    - b. Hypertension, ischemic heart disease, or history of stroke; or,
  3. If the AHI > 30 or the RDI > 30 and meets either of the following (a or b):
    - a. The beneficiary is not able to tolerate a positive airway pressure (PAP) device; or,

- b. The treating physician determines that the use of a PAP device is contraindicated.
- C. The device is ordered by the treating physician following review of the report of the sleep test. (The physician who provides the order for the oral appliance could be different from the one who performed the clinical evaluation in criterion A.)
- D. The device is provided and billed for by a licensed dentist (DDS or DMD)."

Whereas LCDs specify the conditions that determine whether the item or service is reasonable and medically necessary, the related Policy Articles detail the requirements that must be met for an oral appliance to be classified as DME and coded as E0486. Code E0486 may only be used for custom-fabricated mandibular advancement devices. Moreover, only oral appliances that have undergone coding verification review by the PDAC Contractor are eligible for Medicare reimbursement.

To be coded as E0486, custom-fabricated mandibular advancement devices must meet all of the following criteria:

- Have a fixed mechanical hinge at the sides, front or palate; and,
- Have a mechanism that allows the mandible to be advanced by the patient in increments of one millimeter or less; and,
- Be able to protrude the mandible beyond front teeth when adjusted to maximum protrusion; and
- Retain the adjustment setting when removed from the mouth; and,
- Maintain the adjusted mouth position during sleep; and,
- Remain fixed in place during sleep so as to prevent dislodging the device; and,
- Require no return dental visits beyond the initial 90-day fitting and adjustment period to perform ongoing modification and adjustments in order to maintain effectiveness.

Items that require further adjustments beyond the initial 90-day period after delivery of the oral appliance are not eligible for classification as DME. These items are considered dental therapies, which are not eligible for reimbursement by Medicare under the DME benefit. They must not be coded using E0486.

Custom-fabricated mandibular advancement devices that do not incorporate all of the criteria above must be coded as A9720 (non-covered item or service).

Billing for oral appliance therapy is all-inclusive. The lump-sum payment derived from the DMEPOS Fee Schedule includes all time, labor, materials, professional services, radiology and laboratory costs incurred in fabricating and fitting the device, as well as adjustment and professional services required during the 90 days following the initial placement. The reimbursement is payable only by the regional DME MAC, not the Part B local carrier.

According to Policy Article A51783, "Medicare claims related to the fitting, initial/ subsequent adjustments and repairs of an oral device should be submitted to the appropriate DME MAC and not as evaluation and management (E/M) services to the A/B MAC. Additionally, any radiological or other services performed in order to guide the adjustments of the oral device should not be submitted separately to the A/B MAC, as the Medicare payment associated with HCPCS code ... E0486 already includes any required adjustments to ensure a properly fitted device.....services related to the [E0486]code - including initial patient evaluation, any required imaging, all fitting and post fabrication adjustments - are contained in the code and payable only by the DME MAC."

The HCPCS encompasses both billable and payable codes. A billable HCPCS code is one that is submitted on a claim to the DME MAC. A payable HCPCS code is one that is considered for payment by the DME MAC only if the item meets the definition of durable medical equipment, falls under a statutory benefit category, and meets all other statutory and regulatory requirements.

In terms of Medicare reimbursement, HCPCS code E0486 is the only reimbursable code for oral appliance therapy for obstructive sleep apnea. HCPCS codes A9270, E0485, and E1399 are not payable codes, but rather only billable codes.

- A9270: Non-covered item or service (Used for oral appliances that do not incorporate all of the criteria as set forth in the Policy Article; tongue-retaining or tongue-positioning devices; and devices that are used only to treat snoring without a diagnosis of obstructive sleep apnea)
- E0485: Oral device / appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment (Coverage denied on the basis of not reasonable or medically necessary; there is insufficient evidence to show that these devices are effective therapy for obstructive sleepapnea.)
- E0486: Oral device / appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom-fabricated, includes fitting and adjustment

- E1399: Durable medical equipment, miscellaneous

When appropriate, certain HCPCS modifiers may need to be appended to the claim. HCPCS modifiers indicate that an item or service has been altered by a specific circumstance but not changed in its definition or code. HCPCS modifiers for oral appliance therapy may include:

- KX: Requirements specified in the medical policy have been met
- EY: No physician order, or other licensed health care provider order, for this item or service
- GA: Waiver of liability statement issued, as required by payer policy (Item or service expected to be denied as not reasonable and necessary; Advance Beneficiary Notice of Non-coverage on file)
- GZ: Item or service expected to be denied as not reasonable and necessary (No Advance Beneficiary Notice of Non-coverage on file)
- NU: Purchase of new equipment

The only ICD-10-CM code that supports medical necessity of oral appliance therapy is: G47.33 Obstructive sleep apnea.

According to 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is 5 years unless the Medicare program authorizes a specific reasonable useful lifetime (RUL) of less than 5 years for the item. Thus, oral appliances are eligible for replacement at the end of their 5-year RUL. Prior to the expiration of the 5-year RUL, oral appliances may be replaced as a result of loss, theft or irreparable damage caused by a specific accident or natural disaster; however, they may not be replaced prior to the expiration of their 5-year RUL due to wear-and-tear from everyday use.

### **Documentation Requirements**

Dental professionals, as DMEPOS suppliers, must have a written order on file from the treating physician before dispensing an oral appliance to a Medicare beneficiary. Dentists may not generate the written order for oral appliance therapy themselves since they are not licensed to perform and interpret sleep tests and diagnose obstructive sleep apnea.

The written order must contain:

- Beneficiary's name

- Physician's name, legible signature and signature date
- Date of the order
- Detailed description of the item

The detailed description in the written order may be either a narrative description or a brand name/model number. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or original pen-and-ink document. Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements.

The written order must be maintained in the dentist's files for 7 years and available to Medicare contractors upon request. If the dentist does not have a signed order before submission of the claim for Medicare payment, the claim will be denied.

Additionally, for DMEPOS items to be covered by Medicare, the medical record must contain sufficient documentation of the medical condition to substantiate medical necessity for the item ordered. Section 1833(e) of the Social Security Act precludes payment to any service provider unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider."

Since physicians are the ones diagnosing and treating the Medicare beneficiaries, the dental professional must obtain from them copies of their office notes, pertinent test reports, and other healthcare records to substantiate the reasonableness and medical necessity for the oral appliance ordered. The documentation in the patient's medical record does not have to be routinely forwarded to the dental professional or to the DME MAC. However, the DME MAC may request this information in selected cases.

If the DME MAC does not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the dentist is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

To fulfill Medicare requirements, the information in the medical record should include evidence that the treating physician conducted a face-to-face clinical evaluation prior to the sleep study to assess the patient for obstructive sleep apnea. The clinical evaluation should be documented in a detailed narrative note in the patient's chart in the format that the physician uses for other entries. At a minimum, the clinical evaluation should include

information about:

#### Medical History

- Signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches
- Duration of symptoms
- Validated sleep hygiene inventory such as the Epworth Sleepiness Scale

#### Physical examination

- Body mass index
- Neck circumference
- Focused cardiopulmonary and upper airway evaluation.

The information in the medical record should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course, prognosis, and therapeutic interventions and results. Neither the physician's order, a supplier's prepared statement nor a physician's attestation by itself, provides sufficient documentation of medical necessity, even though signed by the treating physician or supplier. There must be information in the patient's medical record to substantiate the information in these documents. Moreover, the patient's medical record is not limited to the physician's office records but may also include hospital, nursing home, or home health agency records and records from other health care professionals.

Once the oral appliance is custom-fabricated and delivered to the patient, the dental professional is also required to maintain proof of delivery documentation. Proof of delivery is a Medicare Supplier Standard.

For medical review purposes, proof of delivery serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. The DME MAC must be able to determine from delivery documentation that the supplier properly coded the item, that the item delivered is the same item submitted for Medicare reimbursement and that the item is intended for, and received by, a specific Medicare beneficiary.

The proof of delivery record must include:

- Beneficiary's name, signature and date of signature;
- Delivery address
- Date of delivery
- Detailed description of item (brand name, narrative description); quantity delivered.

The date of signature must be the date that the item is received by the Medicare beneficiary or designee.

At the time of delivery of the oral appliance, the dental professional is also responsible for providing instruction to the Medicare beneficiary on the safe, proper and effective use and care of the oral appliance; this instruction must be documented, signed and dated in the medical records.

All claims for payment of oral appliances that do not have appropriate proof of delivery documentation will be denied. Dental professionals must maintain all required documentation for 7 years after the claim has been paid.

### **ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE**

The **Advance Beneficiary Notice of Noncoverage** (ABN), Form CMS-R-131, is a standard form issued by providers and suppliers to Medicare beneficiaries stipulating that Medicare is likely to deny payment for the specific claim, and that if Medicare denies the claim, the Medicare beneficiary will be liable for the full cost of the item or service.

The purpose of the ABN is to inform the Medicare beneficiary, before he or she receives an item or service that Medicare will probably not pay for that particular item or service on that particular occasion. 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.

There are several circumstances which trigger the mandatory issuance of an ABN. An ABN is required, for example, when Medicare coverage is likely to be denied because the item or service is not considered medically reasonable and necessary (Section 1862(a)(1) of the Social Security Act). An ABN is also required under Section 1834(j)(1) of the Social Security Act when the supplier has not fulfilled the requirements for obtaining a Medicare supplier number and therefore is not enrolled in the Medicare program. As a condition of payment, the supplier must be enrolled in the Medicare program.

If an ABN is not issued as required, the supplier may not shift financial liability for such items or services to the Medicare beneficiary should the claim be denied by Medicare. The Medicare contractor will hold any supplier who either fails to give notice when required or

issues a defective notice financially liable.

Thus, if the Medicare beneficiary knew, or could have been reasonably expected to know, that the item or service would not be covered, the Medicare beneficiary is liable for the charges. If the Medicare beneficiary did not know, but the supplier knew or could have been reasonably expected to know, that the item or service would not be covered, liability for the charges rests with the supplier.

For an ABN to be valid, the ABN must be provided using the correct OMB-approved notice with all required blanks completed; issued far enough in advance of delivery of potentially non-covered items or services to allow sufficient time for the Medicare beneficiary to consider all available options; explained in its entirety with all of the Medicare beneficiary's questions answered to the best of the supplier's ability; and signed and dated by the Medicare beneficiary or his or her representative.

The ABN essentially presents the Medicare beneficiary with two choices: 1) whether to accept or decline treatment; and 2) if treatment is elected, whether the supplier should or should not submit the claim to Medicare for an official determination on payment.

By electing to accept the item or service, the Medicare beneficiary acknowledges responsibility for payment of the item or service should Medicare deny the claim. If the claim is denied, the supplier is not restricted by any limitation on charges that otherwise would have been in effect if the item or service had been covered. The supplier may charge the Medicare beneficiary an amount greater than the Medicare-allowed amount.

ABNs do not apply to services that are statutorily excluded from Medicare coverage, such as routine dental services. However, an ABN may be issued voluntarily. The voluntary ABN serves as a courtesy to the Medicare beneficiary to forewarn him or her of potential financial obligation. When an ABN is issued voluntarily, the supplier is not required to adhere to the issuance guidelines; the beneficiary is not required to select an option box or sign the document.

An ABN is effective for one year and must be retained in the medical records for 5 years from date of service or delivery of the item. Document retention is required in all cases including cases in which the Medicare beneficiary declines care, refuses to choose an option, or refuses to sign the notice.

For further information on the ABN, the ABN form and instructions may be downloaded from <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

## **OPTING-OUT OF THE MEDICARE PROGRAM**

All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, Section 1848 (g)(4) of the Social Security Act requires that all



providers and suppliers submit claims to Medicare on behalf of its beneficiaries for items or services covered by the Medicare program.

Section 1848(g)(4) of the Act, regarding mandatory claims submission, does not apply once a provider or supplier signs and submits an affidavit to the Medicare contractor **opting out of the Medicare program**. Section 1802 of the Social Security Act permits certain health care practitioners, including doctors of dental surgery or dental medicine, to opt out of the Medicare program and enter into private contracts with Medicare beneficiaries.

By opting-out of the Medicare program, the dental professional is not required to submit claims on behalf of the Medicare beneficiary, is not subject to the reporting requirements of Medicare-enrolled providers and suppliers, and is not restricted by limitations on charges for Medicare-covered items or services.

Opting out requires that the dentist enter into a private contract with each Medicare beneficiary for the purpose of providing items or services that otherwise would be covered by the Medicare program. The private contract essentially states that neither the dentist nor the Medicare beneficiary may submit bills to, or receive payments from, Medicare for items or services provided. Instead, the Medicare beneficiary pays the dental professional out-of-pocket without regard to any limits on charges that otherwise would apply; neither party is reimbursed by Medicare.

The dental professional cannot choose to opt out of the Medicare program for some Medicare beneficiaries but not others, or for some services but not others. The contract must be signed before the items or services are provided so that the Medicare beneficiary is fully aware of the dentist's opt-out status. Medicare beneficiaries who enter into private contracts with dentists are not precluded from receiving services from other dental professionals who have not opted out of the Medicare program.

A private contract is not needed to provide services that are statutorily excluded from Medicare coverage, such as routine dental services. For these services, dentists are not required to submit claims to Medicare on the beneficiary's behalf and limits on the amount of the charges do not apply.

An **opt-out private contract** must:

- Be in writing and in print sufficiently large to ensure that the Medicare beneficiary is able to read the contract;
- State whether the dental professional is excluded from the Medicare program;

- State that the Medicare beneficiary accepts full responsibility for payment of the dentist's charges for all items and services provided;
- State that the Medicare beneficiary understands that Medicare limits on charges do not apply;
- State that the Medicare beneficiary agrees not to submit a claim to Medicare or ask the dentist to submit a claim to Medicare on his or her behalf;
- State that the Medicare beneficiary understands that Medicare will not pay for any items or services provided by the dentist that would have been otherwise covered by Medicare if no private contract existed;
- State that the Medicare beneficiary enters into the contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from dental professionals who have not opted-out;
- State the expected or known effective dates of the duration of the opt-out period.
- State that the Medicare beneficiary understands that **Medigap** plans do not, and that other supplemental plans may not, make payments for items or services not reimbursed by Medicare.
- Not be entered into during a time when the Medicare beneficiary requires emergency or urgent care;
- Be provided (photocopy permissible) to the Medicare beneficiary before items or services are provided under the terms of the contract;
- Be signed by the Medicare beneficiary (or legal representative) and by the dental professional.
- Be retained (original signatures of both parties required) by the dental professional for the duration of the opt-out period;
- Be made available to CMS upon request; and
- Be entered into for each opt-out period.

In order for the private contract with a Medicare beneficiary to be effective, the dentist must submit an affidavit to all Medicare contractors to which the dentist would submit claims, regarding his or her decision to opt out and privately contract with Medicare

patients. The affidavit must be filed within 10 days of entering into the first private contract with a Medicare beneficiary.

Under 1802(b)(3)(B) of the Social Security Act, a valid **opt-out affidavit** must:

- Be in writing and signed by the dentist;
- Contain the dentist's full name, address, telephone number, national provider identifier (NPI) or billing number (if one has been assigned), or, if an NPI has not been assigned, the dental professional's tax identification number (TIN);
- State that, except for emergency or urgent care, the dentist will provide Medicare-covered services to Medicare beneficiaries only through private contracts during the opt-out period;
- State that the dentist will not submit a claim to Medicare for any service rendered to a Medicare beneficiary during the opt-out period or permit any entity acting on his or her behalf to submit a claim to Medicare for services rendered except for emergency or urgent care;
- State that the dentist understands that during the opt-out period he or she may receive no direct or indirect Medicare payment for services rendered to Medicare beneficiaries with whom the dentist has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for services rendered to a Medicare beneficiary under a Medicare Advantage plan;
- Acknowledge that the dentist understands that during the opt-out period, his or her services are not covered under Medicare and that no Medicare payment may be made to any entity for his or her services directly or on a capitated basis;
- Acknowledge that during the opt-out period the dentist agrees to be bound by the terms of the affidavit and the private contracts into which the dentist has entered;
- Acknowledge that the dentist recognizes that the terms of the affidavit apply to all Medicare-covered items and services provided by the dentist to the Medicare beneficiary during the opt-out period (except for emergency or urgent care provided to the Medicare beneficiary not previously privately contracted) without regard to any payment arrangements made by the dentist;

- Acknowledge that for the dentist who has signed a Medicare participation agreement, such agreement terminates on the effective date of the affidavit;
- Acknowledge that the dentist understands that a Medicare beneficiary who has not entered into a private contract and who requires emergency or urgent care may not be asked to enter into a private contract with respect to receiving such services and that the rules for emergency or urgent care apply if such services are provided; and
- Identify the dentist sufficiently so that the Medicare contractor can ensure that no payment is made to the dentist during the opt-out period; both enrolled and non-enrolled dentists may opt out of the Medicare program.

If the dental professional fails to properly opt-out in accordance with the opt-out conditions or fails to remain in compliance with the opt-out conditions during the opt-out period both the private contract and opt-out affidavit are rendered null and void.

Pursuant to the statute, once the dentist files the affidavit the dentist is out of the Medicare program for two years from the date that the affidavit is signed. At the end of the two years, the dentist may either elect to return to the Medicare program or opt out again by re-filing another affidavit.

- For further information on the Medicare opt-out affidavit, visit <https://med.noridianmedicare.com/web/jeb/enrollment/opt-out>

## Coding and Billing

*The following information represents only an overview of coding and billing. Dental professionals are advised to obtain both a HCPCS level II codebook and a CPT codebook for specific code information. The dental professional also will need policy information specific to each insurer prior to submitting a claim, as coverage policies vary among insurers.*

The coding systems for medical and dental services are different. Dental practitioners report their procedures to insurers using CDT codes, whereas medical procedures are reported using CPT and HCPCS codes. For billing dental procedures, dental insurers require only a procedure code, whereas medical insurers require both an **ICD-10-CM** (International Classification of Diseases 10th Edition, Clinical Modifications) diagnosis code and a **HCPCS** (Healthcare Common Procedure Coding System) code for the services and items provided. Medical claims must also include sufficient information to justify the medical necessity of the particular procedure.

The Healthcare Common Procedure Coding System was established in 1978 to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. The HCPCS coding system is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (**Current Procedural Terminology**), a numeric coding system maintained by the American Medical Association. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Providers and suppliers use these codes on insurance claim forms to identify items and services provided to patients.

The HCPCS coding system is not a methodology for making coverage or payment determinations. It does not imply that any payer will cover the items in the code category. Each payer makes determinations on coverage and payments outside of this coding process.

### HCPCS LEVEL I (CPT) CODING

Level I of the HCPCS is comprised of Current Procedural Terminology (CPT) codes, which are maintained and copyrighted by the American Medical Association (AMA) and used primarily to identify medical services and procedures provided by physicians and other healthcare professionals. The CPT codebook includes descriptions of each service assigned a code and guidelines for using these codes on insurance claim forms. Each service is identified with a five-digit numeric codes or codes with four digits followed by an alpha character.

Dental professionals using the codes in the CPT codebook are advised to keep a current copy of the codebook on-hand in their office. Prior to submitting claims using CPT

codes, the dental professional should review the introduction of the codebook for coding guidelines. In using the codes:

- Select the name of the procedure or service that accurately identifies the service performed.
- Do not select a code that merely approximates the service provided.
- If no specific code exists, then report the service using the appropriate unlisted procedure or service code.
- Any procedure or service performed should be adequately documented in the medical/dental record.

## **HCPCS LEVEL II**

Level II of HCPCS is a standardized coding system used primarily to identify products and supplies that are not included in the CPT codes, such as durable medical equipment, orthotics, prosthetics, and supplies. Whereas the CPT codes are identified by 5 numeric digits, the level II HCPCS codes begin with a single alphabetical letter followed by 4 numeric digits.

Dental professionals may be familiar with this set of codes because it contains codes for general dentistry procedures. The code for oral appliance therapy for obstructive sleep apnea (E0486) can be found in the Durable Medical Equipment (DME) section of the codebook. Codes in this section begin with the letter “E” followed by four digits. Coincidentally, DME codes immediately follow the dental procedures codes.

Dental professionals using HCPCS Level II codes are advised to keep a current copy of the codebook on-hand. Because these codes are established and maintained by CMS, the codebook is readily available online free of charge.

In some instances, providers and suppliers are required to also use code modifiers with the HCPCS codes to provide additional information regarding the item or service being billed. **Code modifiers** supplement the information provided by the code in many ways. For example, code modifiers may indicate whether all requirements for coverage have been met or that special circumstances exist that may affect payment.

## **INTERNATIONAL CLASSIFICATION OF DISEASES – 10<sup>TH</sup> EDITION – CLINICAL MODIFICATION (ICD-10-CM) DIAGNOSIS CODES**

The International Classification of Diseases 10<sup>th</sup> edition (ICD-10-CM) is a codebook for diagnosis codes developed by the World Health Organization in association with the

American Medical Association. The ICD-10-CM diagnosis codes are used by many health care providers and suppliers to describe conditions and diseases affecting the patient's health.

ICD-10-CM coding:

- Converts descriptions of diseases, injuries, conditions and procedures into numerical designations (codes);
- Helps to establish the medical necessity of a service;
- Provides data for medical research, education and administration; and
- Provides statistics for morbidity and mortality rates.

The ICD-10-CM codes consist of three to seven characters; the first digit is an alpha character and the subsequent characters are numeric. For example the ICD-10-CM code for obstructive sleep apnea is G47.33.

In selecting the appropriate ICD-10-CM code, first identify the reason for the visit (for example, clinical sign, symptom, diagnosis, or condition). Patients' conditions are often described using terminology that includes specific diagnoses as well as symptoms, problems or reasons for the visit. If symptoms are present but a definitive diagnosis has not yet been determined, code the symptoms. Do not code conditions that are referred to as "rule out," "suspected," "probable" or "questionable" – instead code the known signs and symptoms.

Also, when coding the symptom or diagnosis, code to the highest level of specificity known at the time of the encounter. For example, do not use a three- or four-digit code when a five-digit code is mandatory in that specific category.

In terms of oral appliance therapy, the diagnosis of obstructive sleep apnea must be made by the referring physician, not the dentist. Thus, when the dental professional submits a claim to the insurer for an oral appliance, the patient's diagnosis listed on the claim form should be based on the information provided by the referring physician.

# Office Protocols for Reimbursement

## CLAIMS SUBMISSION

Dental professionals are advised to develop specific office protocols for submitting claims to all types of third-party payers on behalf of their patients. The universal standard claim form accepted by all insurance carriers for billing durable medical equipment is the **CMS-1500 claim form**. A completed medical claim for oral appliance therapy will include procedure and diagnosis codes for the service(s) provided. Most dental professionals will submit their claims electronically, though paper forms are available. Each insurance company has its own mechanism for claims submission. In all cases, the dental professional should have the patient sign a financial agreement outlining the fee, what will be provided, and how the patient plans to pay the fee.

## PRE-AUTHORIZATION

In some cases, an insurance company may require **pre-authorization** prior to claims submission for oral appliance therapy. The process of pre-authorization allows the insurance company to review medical necessity for the device in advance to determine if the patient's condition and the proposed device meet the insurer's criteria for reimbursement. An insurance company will outline its process for pre-authorization, which can often be done over the phone. Approval is generally granted verbally and then followed-up with a formal letter stating that medical necessity has been established and the procedure requested is a covered benefit. Denied pre-authorizations can be appealed by letter or telephone call.

## PRE-DETERMINATION

If pre-authorization is not required, patients may request information regarding whether or not their insurance company will cover oral appliance therapy. This request, known as a **pre-determination request**, is a voluntary process. A pre-determination request is usually filed with the insurer in a similar manner as the claim. The dental professional will submit a claim form with the code that will be used for the oral appliance. The claim should not include a date of service (because the appliance has not yet been delivered). The dental professional should also mark the claim clearly at the top with the term "pre-determination request."

It may be necessary to submit documentation with the pre-determination claim. The following list of information is recommended when submitting pre-determinations:

- Prescription for the oral appliance from the referring physician;
- Letter of medical necessity from the physician;



- Diagnosis code(s);
- CPAP intolerance affidavit (if warranted);
- Treatment code(s);
- Documentation of the patient’s visit; and
- References (for example, AASM Practice Parameters and Clinical Guidelines).

The dental professional will receive one of three responses to a pre-determination request: “yes,” “no” or “not available under contract.” A response of “yes” is not a guarantee of payment. If a response of “no” is received, an **appeal** can be submitted by letter or telephone call. The dental professional should maintain records of all interactions with insurance companies to make future claims submissions easier.

## **APPEALS PROCESS**

In the event that a claim for a service provided by a dental professional is denied, the dental professional has the right to appeal the insurer’s decision on the patient’s behalf. The denial notice should provide the specific reason for the denial of the claim along with instructions on the appeals process. The Explanation of Benefits (EOB) from the insurer may also contain a statement about how to appeal a decision.

Broadly, there are two methods of appeal: internal and external. The internal appeal is the first step of the appeals process whereby the insurer is formally requested in writing to reconsider its decision. In many insurance companies, claims may be reviewed on appeal several times by different groups of reviewers with varying levels of expertise. For example, if the initial appeal is denied, a second or even third request for reconsideration of the decision may be allowed. At each level of appeal, different plans have different time limits for submitting the appeal documents, so it is important to follow the appeals process specific to the particular insurance plan.

Many disputes are resolved during the internal appeals process. However, if the insurance company continues to deny the claim and all internal appeals have been exhausted, patients then have the right to request that the state insurance commissioner’s office perform an independent review of the dispute. The external review of the claim is conducted by an independent board of qualified experts outside of the health plan and this board of experts decides whether to uphold or overturn the plan’s decision.

With respect to oral appliance therapy, claims are often denied on the grounds that the treatment is not medically necessary. Insurance representatives are often uncertain as

to the nature of oral appliance therapy when it is performed in a dental office. Thus it is important to emphasize that the treatment is for a medically necessary condition, not a *dental condition*. The letter of appeal should include supporting documentation from the referring physician, for example, the polysomnography results, letter of medical necessity, prescription for oral appliance therapy and proof of CPAP intolerance (See Resources Section, Sample Appeals Letter). Throughout the appeals process, it is always a good idea to document all communications with the insurance company and to keep a copy of all written correspondence received and submitted.

## **GLOSSARY**

### **Advance Beneficiary Notice of Noncoverage (Form CMS-R-131)**

A written standardized notice issued to the Medicare beneficiary by the dentist, prior to providing certain item(s) or service(s), stating that Medicare is likely to deny coverage of the item(s) or service(s). Under normal circumstances Medicare would cover the item(s) or service(s), however in this particular instance Medicare is not likely to cover the item(s) or service(s) for reasons stated in the notice. The notice advises the patient that if he or she chooses to move forward with treatment, he or she will be fully responsible for payment if Medicare denies coverage.

### **Allowable Charge**

The maximum amount that an insurer will pay for any specific covered service.

### **Appeal of Claim Denials**

Action taken by the patient or dental professional in response to an insurer's denial of coverage or payment for a claim or preauthorization / predetermination request. The appeal, which may be made by phone or by letter, is a request for the insurance carrier to reevaluate and reconsider its adverse decision.

### **Assignment of Benefits**

A process whereby the patient authorizes the administrator of the insurance plan to forward payment for a covered procedure directly to the treating dental professional.

### **Balance Billing**

The practice of billing patients for the difference between the amount reimbursed by the insurer for the given item or service and the amount that the healthcare provider customarily charges. Network providers are contractually prohibited from balance billing, whereas balance billing is common among out-of-network providers.

### **Claim**

A request for payment of insurance benefits for services rendered by a healthcare professional or supplier. Claims may be submitted to the insurance carrier by the patient directly or by the healthcare professional or supplier on behalf of the patient. Along with the claim, third-party payers may require submission of additional documentation (for example, certificates or letters of medical necessity, test reports, and/or narratives with supplementary information) pertinent to determination of the benefit.

### **CMS**

Acronym for Centers for Medicare and Medicaid Services.

## **Coding Modifier**

Two-digit alphanumeric code used in conjunction with another code to generally indicate that a service or procedure has been altered.

## **Coinsurance**

The percentage of the allowed amount (usually 20%) that the patient is required to pay after paying the annual deductible. The insurer pays the remainder of the allowed amount.

## **Copayment**

The fixed amount that the patient must pay for covered service at the time that the service is provided.

## **Current Procedural Terminology (CPT)**

A standard universal code set, developed and copyrighted by the American Medical Association, that is used for reporting medical procedures and services. The AMA approves all CPT codes and updates them annually. CPT codes are also known as Level I HCPCS codes.

## **Deductible**

The fixed amount that the patient is required to pay annually before the insurer will begin to pay on the claim.

## **Durable Medical Equipment (DME)**

Items of medical equipment that are primarily and customarily used for a medical purpose, generally not useful in the absence of injury or illness, appropriate for use in the home, and able to withstand repeated use. By definition, medical equipment must be durable meaning that the item must have an expected life of at least three years.

## **Durable Medical Equipment Medicare Administrative Contractor (DME MAC)**

A private insurance company contracted by CMS to administer the Medicare program at the local level to DMEPOS suppliers. There are four regional DME MACs, each assigned to one of the four jurisdictions (A-D) across the United States. . DME MACs serve as the primary point of contact for DMEPOS suppliers on issues regarding enrollment, coverage, billing and claims appeals.

## **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier**

An entity or individual that sells or rents Part B covered DMEPOS items to Medicare beneficiaries. DMEPOS suppliers must be in compliance with Medicare DMEPOS Supplier Standards.

## **Explanation of Benefits (EOB)**

An EOB form is a statement issued by an insurance carrier to patients explaining the medical procedures and services paid for on their behalf. An EOB typically describes the service performed (date of service, description and/or insurer's code for the service, name of the person or place that provided the service, and name of the patient), the charges billed by the provider, the allowable amount for the service, the amount paid by the insurer, and the amount owed by the patient. If claims are denied, the EOB form will include a brief explanation of the reason for denial of the claim along with instructions for appealing the benefit decision.

## **Gap Waiver**

A gap waiver allows the out-of-network dental professional to be awarded in-network benefits for the service provided. Gap waivers can be requested at any time in which an insurance plan has no qualified in-network provider or supplier to provide the service.

## **Healthcare Common Procedural Coding System (HCPCS)**

A medical coding system that identifies health care services, equipment, and supplies for the purpose of claims processing and reimbursement. HCPCS coding is divided into two primary subsystems: Level I and Level II. Level I HCPCS coding includes the numerical 5-digit CPT code set maintained by the American Medical Association. Level II HCPCS coding consists of an alphanumeric code set, maintained by CMS, that is used to identify services, equipment and supplies not included in the CPT code set, such as durable medical equipment.

## **Health Insurance Claim Form 1500**

Form CMS-1500 is the standard paper claim form used by healthcare professionals and suppliers to bill both government and commercial health insurance carriers for services rendered.

## **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)**

A numeric classification of descriptions of diseases, injuries, and causes of death. Medicare, Medicaid and private health insurance plans require providers to include diagnosis codes on each claim submitted for payment.

## **Indemnity Plan**

Also known as “fee-for-service” plans, indemnity insurance plans enable patients to freely choose their doctor or specialist without any restriction or limitation on their choice of health care provider. Once the annual deductible is met, the insurance carrier either pays the actual charges or more typically pays a percentage of the “usual, customary and reasonable rate” for the service. The patient is responsible for any coinsurance / copayment if applicable.

## **In-Network Provider**

Prescreened health care professionals contracted by an insurance carrier to provide services to its plan beneficiaries at a negotiated discounted rate. The contracted rate includes both the insurer’s and the patient’s share of the cost. Patients pay their share of the cost in the form of an annual deductible, coinsurance or copayment. Network providers are contractually prohibited from balance billing.

## **Limiting Charge**

The highest amount that “non-participating” providers can charge patients for an item or service when they do not accept assignment. For Medicare claims, the limiting charge restriction does not apply to suppliers of durable medical equipment.

## **Local Coverage Determination (LCD)**

An LCD is a decision by a Medicare Administrative Contractor (MAC), fiscal intermediary, or carrier regarding whether to cover a particular item or service within the contractor’s jurisdiction. LCDs may further define National Coverage Determinations (NCD) or provide guidance for services in the absence of an NCD. The LCDs specify under what clinical circumstances an item or service is considered to be reasonable and necessary. They are administrative and educational tools to assist providers in submitting correct claims for payment.

## **Managed Care Plans**

Insurance plans that contract with area health care providers to provide services to plan beneficiaries at a discounted rate in exchange for patient referrals. Generally, plan members must go to these contracted providers in order to receive non-emergency services. Managed care plans include health maintenance organizations (HMO), exclusive provider networks (EPO), preferred provider organizations (PPO), and point-of-service (POS) plans.

## **Medicare Administrative Contractor**

The Medicare program is administered at the local level by independent contractors, usually private health insurance companies.

## **Medicare Part B**

The Medicare program consists of four different plans, one of which is Part B, supplemental medical insurance. Part B of the Medicare program broadly covers outpatient services such as physicians' services, diagnostic tests, home health care, preventive services and medical equipment and supplies. To more efficiently process claims, Part B is further subdivided into two sections: one for medical / surgical service claims and the other for DMEPOS claims. The Part B section that oversees medical / surgical claims is administered by 15 local carriers, whereas the section overseeing DMEPOS claims is administered exclusively by 4 regional carriers.

## **Medigap**

An insurance policy offered by private insurance companies to fill gaps in Medicare coverage. Medigap policies typically cover the Medicare beneficiary's coinsurance and annual deductible.

## **National Coverage Determination (NCD)**

NCDs are developed by CMS to describe the circumstances for Medicare coverage nationwide for an item or service. NCDs generally outline the conditions for which an item or service is considered to be covered (or not covered) under §1862(a) (1) of the Social Security Act or other applicable provisions of the Act.

## **National Provider Identifier (NPI)**

A unique 10-digit identification number for health care providers required for claims submission.

## **Non-Participating Provider or Supplier:**

A health care professional who declines to accept the insurer's allowed amount as payment in full for covered services rendered to plan beneficiaries. With respect to the Medicare program, a nonparticipating provider / supplier is a provider /supplier who has enrolled in the Medicare program but elects to receive payment in a different method and amount than Medicare providers / suppliers classified as participating. Nonparticipating providers / suppliers may choose to accept assignment, not to accept assignment, or accept assignment on a claim-by-claim basis. Thus, they may receive payment for services rendered either from the Medicare program or from the patient directly. In either case, nonparticipating providers / suppliers are required to submit all claims to Medicare on the patient's behalf. Regardless whether claims are assigned or unassigned, the Medicare reimbursement for nonparticipating providers/ supplier is 5% less than that for participating providers / suppliers. For DME claims only, there is no limit as to the amount that the nonparticipating provider / supplier may charge the patient for items or services rendered.

## **Opting Out of the Medicare Program**

Normally providers and suppliers are required to submit claims to the Medicare contractor on behalf of Medicare beneficiaries for all items and services reimbursed under Part B and they are not allowed to charge Medicare beneficiaries in excess of the limits on charges that apply to the item or service being furnished. However, providers and suppliers may formally opt-out of the Medicare program. By opting out of the Medicare program, the provider /supplier is not required to submit claims on behalf of beneficiaries, is excluded from limits on charges for covered services, and is not subject to reporting requirements. In order to opt out of the Medicare program, the provider or supplier must submit an opt-out affidavit to the Medicare contractor and enter into a private contract with Medicare beneficiaries to provide services that otherwise would be covered by the Medicare program.

### **Opt-Out Affidavit:**

A written statement signed and dated by the provider or supplier notifying Medicare that he or she is opting out of the Medicare program. The affidavit is filed with each carrier that has jurisdiction over claims that the provider or supplier would otherwise file with Medicare, no later than 10 days after entering into the first private contract. The opt-out affidavit is valid for a period of two years.

### **Opt-Out Private Contract**

A contract between a Medicare beneficiary and the provider / supplier who has opted out of the Medicare program stating that the provider / supplier will not bill, nor collect any payment from, Medicare for covered services provided to the Medicare beneficiary and that the Medicare beneficiary accepts full responsibility for payment of the charges for services rendered without any assistance from the Medicare program. Neither the Medicare beneficiary nor the provider / supplier will submit claims to Medicare for the services provided.

### **Out-of-Network Providers**

Health care professionals who have not contracted with an insurance carrier to provide services to its plan beneficiaries at a discounted rate. The amounts charged by out-of-network providers can vary significantly, as there are no contractual limits to the amount that they may charge. Some insurance plans may not reimburse out-of-network providers at all, whereas others may reimburse these providers at a set percentage of the “allowed amount” which is based on the amount that other providers in the area charge (UCR rate). The “allowed amount” may not necessarily be the same as the “contracted rate” upon which reimbursements to in-network providers are based.



### **Participating Provider or Supplier**

A health care professional who agrees to accept the insurer's allowed amount as full payment for covered services rendered to plan beneficiaries. With respect to the Medicare program, participating providers / suppliers enter into an agreement to not only accept the Medicare-approved amount as payment in full for covered services rendered but also accept assignment on all Medicare claims. Participating providers / suppliers may only bill Medicare patients for any unmet deductible and coinsurance.

### **Pre-Authorization**

Process, often required by insurers, of confirming prior to providing an item or service, whether or not the item or service is covered under the terms of the plan benefits. The preauthorization process allows the insurance company to determine whether the proposed item or service is medically necessary and reasonable and whether it fulfills the insurer's criteria for reimbursement.

### **Pre-Determination**

Voluntary process of confirming with an insurer, prior to providing an item or service, whether or not the item or service is covered under the terms of the plan benefits.

### **Pricing, Data Analysis and Coding (PDAC) Contractor**

The PDAC contractor provides support functions to CMS contractors that adjudicate Medicare claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). These functions include coordinating the development of HCPCS codes in support of DMEPOS-related claims processing, policy development, program integrity, and medical review and providing statistical analysis of regional and national DMEPOS claims data.

### **Usual, Customary and Reasonable Rate (UCR)**

The amount that health care providers in the area typically charge for any given procedure or service.

## Website Links

American Academy of Dental Sleep Medicine

[www.aadsm.org](http://www.aadsm.org)

American Academy of Sleep Medicine

[www.aasm.org](http://www.aasm.org)

- AASM Practice Parameters and Clinical Guidelines on Oral Appliance Therapy: Oral Appliances for Snoring and Obstructive Sleep Apnea: A Review. Ferguson KA, Cartwright R, Rogers R, Schmidt-Nowara W. Sleep. 2006 Feb 1; 29(2):244-62
- Practice Parameters for the Treatment of Snoring and Obstructive Sleep Apnea with Oral Appliances: An Update for 2005. Kushida CA, Morgenthaler TI, Littner MR, Alessi CA, Bailey D, Coleman J Jr, Friedman L, Hirshkowitz M, Kapen S, Kramer M, Lee-Chiong T, Owens J, Pancer JP; American Academy of Sleep Medicine. Sleep. 2006 Feb 1; 29(2):240-3.

CMS Home Page

<http://www.cms.gov>

Medicare Home Page

<http://www.cms.gov/Medicare/Medicare.html>

CMS Online Manual System

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>

Medicare Learning Network

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>

CMS Medicare Coverage Database

<http://www.cms.gov/medicare-coverage-database/>

CMS Durable Medical Equipment, Prosthetics, Orthotics Supplies (DMEPOS) Center

<http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html>

Medicare Fraud and Abuse

[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud\\_and\\_Abuse.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud_and_Abuse.pdf)

DME MAC Jurisdiction Map

[http://www.palmettogba.com/palmetto/providers.nsf/files/DME%20MAC%20Jurisdiction%20Map.pdf/\\$File/DME%20MAC%20Jurisdiction%20Map.pdf](http://www.palmettogba.com/palmetto/providers.nsf/files/DME%20MAC%20Jurisdiction%20Map.pdf/$File/DME%20MAC%20Jurisdiction%20Map.pdf)

Jurisdiction A DME MAC

<https://www.noridianmedicare.com>

Jurisdiction B DME MAC

<https://www.cgsmedicare.com>

Jurisdiction C DME MAC

<https://www.cgsmedicare.com>

Jurisdiction D DME MAC

<https://www.noridianmedicare.com>

National Supplier Clearinghouse (NSC)

<http://www.palmettogba.com/nsc>

Medicare Enrollment Application (CMS Form 855S)

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf>

Medicare DMEPOS Supplier Participation Agreement

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf>

Medicare Electronic Funds Transfer Authorization Agreement

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS588.pdf>

Medicare DMEPOS Supplier Standards

[http://www.palmettogba.com/Palmetto/Providers.Nsf/files/supplierstandards30.pdf/\\$File/supplierstandards30.pdf](http://www.palmettogba.com/Palmetto/Providers.Nsf/files/supplierstandards30.pdf/$File/supplierstandards30.pdf)

State Licensing Requirements for Providing DME

[www.palmettogba.com/palmetto/statelicensure.nsf](http://www.palmettogba.com/palmetto/statelicensure.nsf)

Pricing, Data Analysis and Coding (PDAC) Contractor

<http://www.dmepdac.com>

National Plan and Provider Enumeration System (NPPES)

<https://nppes.cms.hhs.gov>

NPI Application/Update Form (CMS-10114)

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10114.pdf>

CMS National Provider Identifier (NPI) Standard

<http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html>

CMS NPI Educational Resources

<http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/education.html>

CMS-1500 Form

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS1500805.pdf>

WPC Claim Adjustment Reason Codes

<http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/>

ICD-10

[www.cdc.gov/nchs/icd9.htm](http://www.cdc.gov/nchs/icd9.htm)

HCPCS

<http://www.icd9data.com/hcpcs/default.htm>

CPT

<https://ocm.ama-assn.org/OCM/CPTRelativeValueSearch.do>

International Classification of Sleep Disorders, 3<sup>rd</sup> edition

<https://www.aasm.org>

Advance Beneficiary Notice of Noncoverage

- [www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html)
- [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN\\_Booklet\\_ICN006266.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf)

Medicare Opt-Out Affidavit

[http://www.palmettogba.com/Palmetto/Providers.Nsf/files/Medicare\\_Opt-Out\\_Affidavit-J1B.pdf/\\$File/Medicare\\_Opt-Out\\_Affidavit-J1B.pdf](http://www.palmettogba.com/Palmetto/Providers.Nsf/files/Medicare_Opt-Out_Affidavit-J1B.pdf/$File/Medicare_Opt-Out_Affidavit-J1B.pdf)