Clinical Review Criteria for Mandibular Advancement Device (MAD) in the Treatment of Obstructive Sleep Apnea (OSA)

I. Criteria for Approval

A. The member has a diagnosis of Obstructive Sleep Apnea (OSA) confirmed by a sleep study. The member has trialed a positive pressure (PAP) device for at least 30 days and is unable to tolerate for one or more of the following reasons:

1. Significant clinical improvement was not demonstrated

2. The device could not be tolerated because of claustrophobia, inability to breathe through nose, pain or increasing levels of discomfort

B. The device is provided and billed for by a licensed dentist (DDS or DMD).

II. Required Documentation

A. Participating Primary Care Physician; Pulmonologist; Ear, Nose and Throat Specialist; or Neurologist confirms in writing to Minuteman Health, Inc. (MHI) that this member does not tolerate a positive airway pressure (PAP) device, or the reason that the use of a positive airway pressure (PAP) device is contraindicated.

B. Requests for replacement or repair of an oral appliance that have previously been authorized by MHI must include the following:

1. A statement verifying the effectiveness of the previous appliance

2. Date that the device was obtained

3. Reason for repair or replacement

C. Requests for replacement or repair of an oral appliance that have not been previously authorized by MHI must include the following:

1. Evidence of a sleep-related breathing disturbance established by a recent authorized sleep study within the last 24 months which documents a diagnosis of OSA

2. A statement verifying the effectiveness of the previous device
3. Date that the device was obtained

4. Reason for repair or replacement

III. What is Not Covered

A. Devices requested for the treatment of snoring

B. Non-prescription, over-the-counter devices

C. Custom fabricated mandibular advancement devices (E1399), that achieve their effect through positioning of the tongue, and prefabricated oral appliances (E0485)

IV. CPT/ ICD-10/ HCPCS Codes

Applicable Coding: Codes may not be all inclusive as the American Medical Association (AMA) code updates may occur more frequently or at different intervals than policy updates. These codes are not intended to be used for coverage determinations.

CPT Codes

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

V. References

NCQA Standard, UM 2, Clinical Criteria for Utilization Management Decisions, Element A


VI. Summary of Changes

06/29/2017

• Under I., Criteria for Approval: Added the following: The member has trialed a positive pressure (PAP) device for at least 30 days and is unable to tolerate for one or more of the following reasons:
  1. Significant clinical improvement was not demonstrated
  2. The device could not be tolerated because of claustrophobia, inability to breathe through nose, pain or increasing levels of discomfort

• Under II., Required Documentation: Added the following:
  B. Requests for replacement or repair of an oral appliance that have previously been authorized by MHI must include the following:
     1. A statement verifying the effectiveness of the previous appliance
     2. Date that the device was obtained
     3. Reason for repair or replacement

  C. Requests for replacement or repair of an oral appliance that have not been previously authorized by MHI must include the following:
     1. Evidence of a sleep-related breathing disturbance established by a recent authorized sleep study within the last 24 months which documents a diagnosis of OSA
     2. A statement verifying the effectiveness of the previous device
     3. Date that the device was obtained
     4. Reason for repair or replacement

• Added disclaimer, updated references and last accessed dates

VII. Review Dates

HNE Review Dates: 2/12/13, 2/11/14, 2/10/15, 2/9/16, 9/13/16, 6/13/17
MHI Review Dates: 10/23/2014, 4/21/2016, 10/20/16, 06/29/2017
Medical Guideline Disclaimer
The treating physician or primary care provider must submit to Minuteman the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Minuteman will not be able to properly review the request for prior authorization. The clinical review criteria expressed herein reflects how Minuteman determines whether certain services or supplies are medically necessary. Minuteman established the clinical review criteria based upon a review of currently available clinical information (including, without limitation clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Minuteman expressly reserves the right to revise these criteria as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by Minuteman. If there is a discrepancy between this policy and a member’s benefit program, the benefit program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the federal government or the Centers for Medicare & Medicaid Services (CMS). Minuteman has adopted the herein policy in providing management, administrative and other services to its members.