MEDICARE GUIDELINES
FOR PATIENTS

Our office is a participating provider with Medicare and as such we must comply with all of their requirements. The following information was taken from the Medicare Guidelines and we hope this will help you better understand whether Medicare might cover the cost of your oral appliance.

Currently, they will pay for an oral appliance only if the following criteria are met:

FOR ANY ITEM TO BE COVERED BY MEDICARE, IT MUST:

1. *Be eligible for a defined Medicare benefit category*
2. *Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member*
3. *Meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.*

If the patient is tolerating positive airway pressure (PAP) such as CPAP, BiPAP or APAP routinely, Medicare will not pay for an oral device because they consider the oral device to be a convenience item. Since PAP therapy is the best treatment available, patients are encouraged to use PAP therapy. Medicare will not pay for both therapies as they feel it would be redundant.

FOR AN ITEM TO BE COVERED BY MEDICARE, a DETAILED WRITTEN ORDER (DWO) must be received by the DME supplier before a claim is submitted. If the supplier bills for an item addressed in the policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

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).*

If all of these criteria (A – D) are not met, the custom fabricated oral appliance (E0486) will be denied as not reasonable and necessary.

Our office will need the following documents in order to process your Medicare and supplemental claims on your behalf:

1. Medical notes from the physician who sent you for the sleep test.
    a. These notes must be dated prior to the sleep study
    b. Include proof of a comprehensive physical exam with a list of your sleep symptoms and an explanation of why you are being referred for sleep testing.
2. A copy of your most recent sleep study.
    a. Your sleep test must meet Medicare standards and be scored by a Board Certified Sleep Physician.
3. A prescription, DETAILED WRITTEN ORDER (DWO) and Letter of Medical Necessity.
    a. The physician's signature must be in ink and rubber stamps cannot be used.

Medicare will only pay for specific oral appliances. You may choose a non-Medicare approved appliance but Medicare will not pay for it and you would have to pay for it yourself. According to Medicare, the frequency limit for replacement of the oral appliance is 5 years. Therefore, if your appliance is damaged, broken or if you have dental work and your appliance no longer fits, Medicare will not pay for any repairs and they will not pay to replace it for 5 years after the date you received it.

Medicare will only pay for an oral appliance in the state in which you file your income taxes and the date on the claim we file with Medicare must match the date you received your oral appliance.

As you know, Medicare is a federal health insurance program and its rules and regulations can be very confusing. Please feel free to call our office with any questions you may have.