NON-SURGICAL TREATMENT OF OBSTRUCTIVE SLEEP APNEA

Policy Number: OUTPATIENT 33.19 T2
Effective Date: April 1, 2014

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The services described in Oxford policies are subject to the terms, conditions and limitations of the Member’s contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage enrollees. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford’s administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded Members and certain insured products. Refer to the Member’s plan of benefits or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the Member’s plan of benefits or Certificate of Coverage, the plan of benefits or Certificate of Coverage will govern.

CONDITIONS OF COVERAGE

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<th>Applicable Lines of Business/Products</th>
<th>This policy applies to Oxford Commercial plan membership</th>
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<tr>
<td>Benefit Type</td>
<td>Durable medical equipment (DME)</td>
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<tr>
<td>Referral Required</td>
<td>No</td>
</tr>
<tr>
<td>Authorization Required</td>
<td>Yes¹</td>
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<tr>
<td>Precertification with Medical Director Review Required</td>
<td>No</td>
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<tr>
<td>Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)</td>
<td>All</td>
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<tr>
<td>Special Considerations</td>
<td>¹Oxford’s Dental Department will review requests for services to be rendered by practitioners of the following specialties: oral surgery, oral/maxillofacial surgery, general or pediatric dentistry, endodontics, periodontics, and orthodontics. All other specialties require review by Oxford’s Durable Medical Equipment team.</td>
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Note:
This policy addresses the use of removable oral appliances and nasal dilators in the treatment of sleep apnea. Coverage for positive airway pressure devices, such as CPAP, BiPAP, APAP or VPAP, may be provided, subject to the benefit and precertification considerations set forth by a Member's certificate of coverage and/or health benefits plan documentation.

COVERAGE RATIONALE

Oxford will provide coverage for removable oral appliances and nasal dilators as outlined below.

I. Removable oral appliances are considered to be medically necessary for treating obstructive sleep apnea when documented by polysomnography. For additional information regarding polysomnography, refer to policy: Polysomnography and Portable Monitoring for Evaluation of Sleep Related Breathing Disorders.

II. Due to insufficient evidence to support medical efficacy, removable oral appliances for treating central sleep apnea will not be reimbursed by Oxford. This type of sleep apnea is caused by impaired neurological function, and these devices are designed to manage physical obstructions.

III. Due to insufficient evidence to support medical efficacy, nasal dilator devices (e.g., Provent®) for treating obstructive sleep apnea will not be reimbursed by Oxford. There is insufficient clinical evidence supporting the safety and efficacy of nasal dilators for treating OSA. Results from available studies indicate that therapeutic response is variable among the participants. Further research from larger, well-designed studies is needed to evaluate the effectiveness of the device compared with established treatments for OSA, to determine its long-term effectiveness and to determine which patients would benefit from this therapy.

Information Pertaining to Medical Necessity Review
Oral appliances

BACKGROUND

Obstructive sleep apnea (OSA) is a breathing disorder that is defined by either a decrease or complete cessation of airflow during sleep. In OSA, airflow is obstructed when the muscles in the back of the throat fail to keep the airway open. Nocturnal respiration in patients with OSA is characterized by apnea (breathing cessation) and hypopnea (marked reduction in breathing volume). The signs and symptoms of untreated OSA include excessive daytime sleepiness, loud snoring, nocturnal choking, apneas or choking witnessed by bed partner, unrefreshing sleep, morning headaches, reduced libido and enuresis. Physiological effects of untreated OSA include fluctuating blood oxygen levels, increased heart rate, chronic daytime hypertension and impaired glucose tolerance/insulin resistance.

Diagnosis and evaluation of sleep apnea syndrome is determined through polysomnography (PSG). According to the American Academy of Sleep Medicine (AASM) the diagnosis of OSA is confirmed if the number of obstructive events† (apneas, hypopneas + respiratory event related arousals) on PSG is greater than 15 events/hour or greater than 5/hour in a patient who reports any of the following: unintentional sleep episodes during wakefulness; daytime sleepiness; unrefreshing sleep; fatigue; insomnia; waking up breath holding, gasping or choking; or the bed partner describing loud snoring, breathing interruptions or both during the patient's sleep (Epstein et al., 2009).

†The frequency of obstructive events is reported as an apnea + hypopnea index (AHI) or respiratory disturbance index (RDI). RDI has at times been used synonymously with AHI,
but at other times has included the total of apneas, hypopneas and respiratory effort related arousals (RERAs) per hour of sleep. When a portable monitor is used that does not measure sleep, the RDI refers to the number of apneas plus hypopneas per hour of recording.

Treatment for OSA includes lifestyle modifications (weight loss, avoidance of alcohol or other agents that decrease upper airway patency), positional therapy, positive airway pressure, oral appliance therapy and surgery. Positive airway pressure therapy may use any one of the following techniques: continuous positive airway pressure (CPAP), automatic positive airway pressure (APAP), bilevel positive airway pressure (BiPAP), variable positive airway pressure (VPAP).

Non-surgical oral appliances, worn during sleep, are intended to treat OSA by keeping the airway open in one of three ways: by pushing the lower jaw forward (a mandibular advancement device or MAD), by preventing the tongue from falling back over the airway (a tongue-retaining device) or by combining both mechanisms (ASAA, 2007).

Oral appliances are recommended for treating OSA in ANY of the following circumstances:

- Mild OSA AND patient is unable to tolerate positive airway pressure (PAP) therapy OR refuses PAP
- Moderate to severe OSA as a component of treatment that includes additional modalities such as PAP therapy with reduced pressure
- As a standalone treatment for moderate to severe OSA, if patient is unable to tolerate PAP therapy OR refuses PAP, although this may not be the most effective therapy.

OSA severity is defined as:

- Mild for AHI or RDI ≥ 5 and < 15
- Moderate for AHI or RDI ≥ 15 and ≤ 30
- Severe for AHI or RDI > 30/hr (Epstein et al., 2009)

A nasal dilator is a removable appliance that is placed just inside the nostril and is secured in place with hypoallergenic adhesive. Using small valves, the device increases pressure inside the nose by creating resistance during exhalation to maintain an open airway during sleep (Ventus Medical website).

**CLINICAL EVIDENCE**

**Oral Appliances**

There is sufficient evidence to conclude that mandibular advancement devices (MAD) can improve sleep-disordered breathing in patients with mild to moderate OSA who prefer it to CPAP, do not respond to CPAP or fail treatment with CPAP. MAD therapy is more effective than placebo therapy but less effective than CPAP therapy for reducing sleep-disordered breathing (Hayes, 2010; updated 2012).

An Agency for Healthcare Research and Quality (AHRQ) comparative effectiveness report states that despite no evidence or weak evidence on clinical outcomes, given the large magnitude of effect on the important intermediate outcomes of apnea-hypopnea index (AHI), Epworth Sleepiness Scale (ESS) and other sleep study measures, overall, the strength of evidence is moderate that mandibular advancement devices (MAD) are an effective treatment for OSA in patients without comorbidities (including periodontal disease) or excessive sleepiness. However, the strength of evidence is insufficient to address which patients might benefit most from treatment. The strength of evidence is insufficient regarding comparisons of different oral devices. Despite no evidence or weak evidence on clinical outcomes, overall the strength of evidence is moderate that the use of CPAP is superior to MAD. However, the strength of evidence is
insufficient to address which patients might benefit most from either treatment. Comparative studies focusing on long-term follow-up and clinical outcomes are needed (Balk et al., 2011).

Holley et al. (2011) conducted a retrospective analysis evaluating the efficacy of an adjustable oral appliance (aOA) in comparison with continuous positive airway pressure (CPAP) for treating obstructive sleep apnea (OSA). A total of 497 patients were given an aOA. The aOA reduced the mean apnea-hypopnea index (AHI) to 8.4 ± 11.4, and 70.3%, 47.6% and 41.4% of patients with mild, moderate and severe disease achieved an AHI < 5, respectively. Patients using an aOA decreased their mean Epworth Sleepiness Score by 2.71 at follow-up. CPAP improved the AHI by -3.43 when compared with an aOA, but when adjusted for severity of disease, this difference only reached significance for patients with severe disease (-5.88). However, 70.1% of all patients achieved an AHI < 5 using CPAP compared with 51.6% for the aOA. Baseline AHI was a significant predictor of achieving an AHI < 5, and age showed a trend toward significance. In comparison with past reports, more patients in this study achieved an AHI < 5 using an aOA. The authors concluded that aOAs are comparable to CPAP for patients with mild disease; however, CPAP is superior for patients with moderate to severe disease.

In a multicenter, randomized controlled trial (n=101), Lam et al. (2007) compared the effectiveness of three commonly used non-surgical treatment modalities in patients with mild to moderate OSA. Treatment groups consisted of conservative measures (sleep hygiene) only, continuous positive airways pressure (CPAP) in addition to conservative measures or an oral appliance in addition to conservative measures. The severity of sleep-disordered breathing was decreased in the CPAP and oral appliance groups compared with the conservative measures group, and the CPAP group was significantly better than the oral appliance group. Overall, CPAP produced the best improvement in terms of physiological, symptomatic and quality of life measures, while the oral appliance was slightly less effective.

A Cochrane review concluded that while CPAP appears to be more effective in improving sleep disordered breathing, there is increasing evidence suggesting that oral appliances (OA) improve subjective sleepiness and sleep disordered breathing compared with a control. Until there is more definitive evidence on the effectiveness of OA in relation to CPAP, with regard to symptoms and long-term complications, it would appear to be appropriate to recommend OA therapy to patients with mild symptomatic OSA, and those patients who are unwilling or unable to tolerate CPAP therapy. OA should not be considered as first choice therapy for OSA where symptoms and sleep disruption are severe (Lim, 2006; updated 2008).

Ferguson et al. (2006) conducted an evidence-based systematic review regarding the use of oral appliances for treating OSA and concluded that overall, patients with mild to severe OSA have a 52% chance of being able to control their sleep apnea using an appliance. Success rates ranged between 14 and 61% among patients with severe OSA (AHI defined as greater than 30 in some studies and great than 40 in others). Better success rates were seen in patients with lower AHI. OAs are on the whole less effective than CPAP but may be better accepted by patients than nasal CPAP in studies where subjects used both treatments. OAs are not recommended as a first line treatment in patients with severe OSA. However, these patients might consider an OA if they have failed CPAP or upper airway surgery, recognizing that the results of OA therapy in severe OSA are unpredictable. The literature now provides better evidence for the efficacy of OAs and indications for use.

Tegelberg et al. (2003) compared two different degrees of mandibular advancement with an intraoral appliance in 74 male patients with mild to moderate obstructive sleep apnea. Thirty-eight patients received a dental appliance with 50% advancement and 36 patients received a dental appliance with 75% mandibular advancement. Somnography was performed pre-treatment and after one year of treatment. Fifty-five patients completed followup after one year of treatment. In the group of 50% advancement, normalization (an apnea index of <5 and apnea/hypopnea index <10) was observed in 79% of the group. In the group of 75% advancement, normalization was observed in 73% of the group. Less than 5% of the patients reported symptoms from the stomatognathic system; one-third of the patients reported headaches more than once a week. Headaches significantly decreased after one year of treatment.
Thirty-five patients diagnosed with obstructive sleep apnea unable to tolerate or non-compliant with CPAP were studied by Prathibha et al. (2003). These patients underwent sleep studies, used intraoral appliances for three months and had a repeat sleep study performed while using the appliance. Thirty-one patients completed the study. Patients with a pre-study AHI <20 benefited from the appliance, while the authors concluded that those patients with a pre-study AHI >20 did not.

Walker-Engstrom et al. (2002) randomized 95 patients with confirmed OSA to treatment with a dental appliance or uvulopalatopharyngoplasty. Patients underwent sleep studies before treatment and 1 year and 4 years after treatment. Thirty-two patients in the dental appliance group and 40 patients in the UPPP group completed the 4-year follow up. Success was defined as a reduction in the apnea index of at least 50%. The dental appliance group had a success rate of 81%; the UPPP group had a success rate of 53%. An apnea index of <5 or an apnea/hypopnea index <10 was observed in 63% of the dental-appliance group and 33% of the UPPP group. The compliance rate of the dental appliance group was 62%. Seventy-five percent of the UPPP group were satisfied with their results and required no further complementary treatment.

Gotsopoulus et al. (2002) evaluated the effect of a mandibular advancement splint (MAS) on daytime sleepiness and a range of other symptoms in 73 patients (59 men, 14 women) with mild to severe OSA. OSA severity subgroups revealed a predominance of moderate and severe OSA, with 41 patients (56%) and 21 patients (29%) in each subgroup, respectively. Using a randomized crossover design, patients received 4 weeks of treatment with MAS and a control device (inactive oral appliance). At the end of each treatment period, patients were reassessed by questionnaire, polysomnography, and multiple sleep latency tests. Participants experienced significantly improved mean sleep latency on the multiple sleep latency test and Epworth sleepiness scale score with the MAS compared with the control device. The proportion of patients with normal subjective sleepiness was significantly higher with the MAS than with the control device (82 versus 62%), but this was not so for objective sleepiness (48 versus 34%). Other OSA symptoms were controlled in significantly more patients with the MAS than with the control device.

In a randomized, controlled crossover study, Mehta et al. (2001) evaluated the efficacy of a mandibular advancement splint (MAS) in 28 patients with mild to severe OSA. Patients underwent three polysomnographs with either a control oral plate, which did not advance the mandible, or a MAS. Complete response (CR) was defined as a resolution of symptoms and a reduction in apnea/hypopnea index (AHI) to <5/hour, and partial response (PR) as a ≥ 50% reduction in AHI, but remaining ≥ 5/hour. Twenty-four patients (19 men, 5 women) completed the protocol. Treatment outcome was similar across all categories of OSA severity, with complete response being achieved in some subjects with moderate and severe OSA. Subjective improvements with the MAS were reported by the majority of patients (96%). There were significant improvements in AHI, oxygen saturation and arousal index with MAS, compared with the control. The control plate had no significant effect on AHI and oxygen saturation. CR (n = 9) or PR (n = 6) was achieved in 62.5% of patients. The MAS is an effective treatment in some patients with OSA, including those patients with moderate or severe OSA.

**Nasal Dilators**

Preliminary evidence suggests that use of the Provent nasal device significantly improves the apnea-hypopnea index (AHI) and some other OSA outcomes during short-term and mid-term use of the device in patients with mild, moderate and severe OSA, compared with baseline values. In addition, compared with a sham device, the improvements were more pronounced. Most of the studies evaluated short-term outcomes (~3 months) although one small prospective open-label study evaluated outcomes at 12 months of Provent use in patients who complied with treatment in the randomized controlled trial (RCT) on this device. The efficacy of the Provent device has not been compared directly with CPAP, or other established OSA treatments. The therapeutic response to the Provent device varied among the patients. It is unclear which factors are predictive of treatment response. There was some evidence that the use of the Provent device improved sleep quality and decreased daytime sleepiness among OSA patients, decreased the
observed amount of snoring and had no effect on sleep architecture. The device was well tolerated and adherence to the device was high. Most adverse events were mild, such as nasal discomfort and dry mouth.

Despite these promising findings, the quality of the evidence was low. Only one study included an appropriate control group, while in the other studies, patients served as their own controls. Sample sizes were small, and there were a fair number of dropouts. Additional limitations included the variable use of high- and standard-resistance devices, self-reported adherence data and a heterogeneous patient population. Overall, there is some evidence to suggest that the Provent nasal device is a safe and efficacious treatment for approximately half of the OSA patient population. However, independent randomized controlled trials are needed to evaluate the effectiveness of the device compared with established treatments for OSA, and to evaluate its long-term effectiveness particularly in terms of morbidity and mortality related to OSA. Moreover, a better understanding of the clinical profile of patients who most likely benefit from this therapy is required (Hayes, 2012).

Berry et al. (2011) conducted a multicenter randomized controlled trial investigating the efficacy of a nasal expiratory positive airway pressure (EPAP) device for treating OSA. Two hundred and fifty patients with mild to severe OSA were randomized to treatment with EPAP (n=127) or a similar sham device (n=123) for 3 months. A total of 229 completed week 1 sleep studies (119 EPAP, 110 sham). This group was the intention to treat (ITT) group. Of these, 173 had an AHI > 5/hour on the device-off night and comprised the modified intention to treat (mITT) group (92 EPAP, 81 sham). One hundred ninety five patients in the ITT group (100 EPAP, 95 sham) and 144 patients in the mITT group (77 EPAP, 67 sham) completed the 3 month study. All patients underwent a baseline clinic evaluation that included the Epworth Sleepiness Scale (ESS). Polysomnography (PSG) was performed on 2 non-consecutive nights (random order: device-on, device-off) at week 1 and after 3 months of treatment. At week 1, the EPAP device significantly decreased the AHI compared to device-off nights and the difference was significantly greater than with the sham device (52.7% versus 7.3%, ITT analysis). At 3 months, 51% of the EPAP device users had a 50% or greater reduction in the AHI on device-on compared to device-off nights. The authors concluded that nasal EPAP significantly reduced the AHI and improved subjective daytime sleepiness compared to the sham treatment in patients with mild to severe OSA with excellent adherence. This study is limited by short follow-up, patient-reported adherence, a large number of exclusion criteria and a modified intention to treat group. A potential for bias exists due to manufacturer sponsorship of the study.

Kryger et al. (2011) conducted a 13 center extension study of the 3-month Berry trial. This study was designed to evaluate the long-term effectiveness of EPAP. Forty-one patients from the EPAP arm who met adherence and efficacy criteria were continued on therapy and returned for polysomnography (PSG) after 12 months of treatment. From the analyzable subject cohort (n=34), results from the 12 month PSGs were compared against their baseline results. Median AHI was reduced from 15.7 to 4.7 events/h (week 1 device-off versus month 12 device-on). The decrease in the AHI (median) was 71.3%. The Epworth Sleepiness Scale decreased from 11.1 ± 4.2 to 6.0 ± 3.2. The median percentage of reported nights used (entire night) was 89.3%. The authors reported that long-term adherence to EPAP was excellent in those who had a positive clinical response at month 3 of the Berry trial. As with the original trial, this study is limited by patient-reported adherence, a large number of exclusion criteria and a modified intention to treat group. A potential for bias exists due to manufacturer sponsorship of the study.

Patel et al. (2011) studied a one way nasal device using expiratory positive airway pressure (EPAP) to identify appropriate patients for the therapy and provide pilot data as to its potential mechanisms of action. Twenty patients with OSA underwent three nocturnal polysomnograms (NPSG) including diagnostic, therapeutic (with a Provent® nasal valve device) and CPAP. Nineteen of the 20 patients tolerated the device. The authors reported that the nasal valve device produced improvement in sleep disordered breathing in 75% of patients with OSA of varying severity, with 50% of patients reaching a clinically significant reduction in RDI. Although the study was not able to establish predictors of success or a definitive mechanism of action, the authors
feel it helps define a restricted list of candidates for further investigation. A potential for bias exists due to manufacturer sponsorship of the study.

Walsh et al. (2011) evaluated tolerability, short-term efficacy and adherence of an expiratory positive airway pressure (EPAP) nasal device in 59 OSA patients who refused CPAP or used CPAP less than 3 hours per night. After demonstrating tolerability to the EPAP device during approximately 1 week of home use, 47 patients (80%) underwent a baseline polysomnomgram (PSG1). Forty-three patients met AHI entry criteria and underwent PSG2 within 10 days of PSG1. Twenty four patients (56%) met prespecified efficacy criteria and underwent PSG3 after 5 weeks of EPAP treatment. Compared to PSG1, mean AHI was significantly lower at both PSG2 and PSG3. For most patients AHI at PSG3 was similar to AHI at PSG2. Device use was reported an average of 92% of all sleep hours. The authors concluded that improvements in AHI and Epworth Sleepiness Scale (ESS) scores, combined with the high degree of treatment adherence observed, suggest that the EPAP device tested may become a useful therapeutic option for OSA. Limitations of the study include lack of randomization and control, small sample size and short term follow-up. A potential for bias exists due to manufacturer sponsorship of the study.

In a multicenter, prospective study, Rosenthal et al. (2009) evaluated the efficacy of a novel device placed in the nares that imposes an expiratory resistance for the treatment of OSA and evaluated adherence to the device over a 30-day in-home trial period. Participants (n=34) with a baseline apnea-hypopnea index (AHI) ≥ 5 were evaluated. Treatment was well tolerated and accepted by the participants. The authors documented an overall reduction in AHI; however, therapeutic response was variable (and at times inconsistent) among the participants. Further research is required to identify the ideal candidates for this new therapeutic option in the management of OSA. A potential for bias exists due to manufacturer sponsorship of the study.

Colrain et al. (2008) conducted a pilot study to test the hypothesis that the application of expiratory resistance via a nasal valve device would improve breathing during sleep in subjects with OSA and in primary snorers. Thirty men and women were recruited for the study. Twenty-four had at least mild OSA (AHI >5), and 6 were primary snorers. Subjects underwent 2 nights of polysomnographic evaluation, one with and one without a new nasal resistance device with the order of nights counterbalanced across participants. The device consisted of a small valve inserted into each nostril calibrated to provide negligible inspiratory resistance, but increased expiratory resistance. Standard polysomnography was conducted to compare participants' sleep both with and without the device, with the scoring conducted blind to treatment condition. The apnea-hypopnea (AHI) and oxygen desaturation (O2DI) indices both significantly decreased, and the percentage of the night spent above 90% saturation significantly increased with device use. The results of this pilot study are suggestive of a therapeutic effect of expiratory nasal resistance for some OSA patients and indicate that this technique is worthy of further clinical study. A potential for bias exists due to manufacturer sponsorship of the study.

Professional Societies
American Academy of Sleep Medicine
The AASM makes the following recommendations:

- Continuous positive airway pressure (CPAP) is the preferred first line therapy for OSA;
- Although not as efficacious as CPAP, oral appliances (OAs) are indicated for use in patients with mild to moderate OSA who prefer OAs to CPAP, do not respond to CPAP, are not appropriate candidates for CPAP, fail treatment attempts with CPAP or fail treatment with behavioral measures such as weight loss or sleep position change;
- Patients with severe OSA should have an initial trial of nasal CPAP because greater effectiveness has been shown with this intervention than with the use of oral appliances. Until there is higher quality evidence to suggest efficacy, CPAP is indicated whenever possible for patients with severe OSA before consideration of oral appliances;
- Follow-up polysomnography should be performed following oral appliance therapy to evaluate response to treatment (Kushida et al., 2006; Epstein et al., 2009).
AASM practice parameters on the treatment of central sleep apnea do not list oral appliances as a treatment option (Aurora, 2012).

**American Sleep Apnea Association**

Oral appliances used to treat sleep apnea are worn in the mouth during sleep. Most appliances work by positioning the lower jaw slightly forward of its usual rest position. This small change is, in many people, enough to keep the airway open during sleep. Oral appliances are most effective in the treatment of mild to moderate sleep apnea, although they do provide a treatment alternative for patients with severe OSA who cannot or will not tolerate positive airway pressure therapy. Sometimes for more complicated sleep apnea, an oral appliance and CPAP are used in combination. In the United States, oral devices to treat OSA cannot be sold over the counter. They must be prescribed and fitted by a dentist who has sleep medicine experience (ASAA, 2012).

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

Oral appliances for OSA are regulated by the FDA, but products are too numerous to list. See the following web site for more information (use product codes LRK or LQZ). Available at: [http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm). Accessed March 18, 2013.


**APPLICABLE CODES**

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the Member’s plan of benefits or Certificate of Coverage. This list of codes may not be all inclusive.

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<th>CPT® Code</th>
<th>Description</th>
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<td>E0485</td>
<td>Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment</td>
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<tr>
<td>E0486</td>
<td>Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment</td>
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<tr>
<td>S8262</td>
<td>Mandibular orthopedic repositioning device, each</td>
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*CPT® is a registered trademark of the American Medical Association.*

**REFERENCES**

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2013T0526F]

**Note:** The medical necessity criteria set forth by this policy apply only to the use of these devices in the treatment of sleep apnea.


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<tr>
<td>04/01/2014</td>
<td>• Replaced references to “MCG™ Care Guidelines, 17th edition, 2013” with “MCG™ Care Guidelines, 18th edition, 2014” (effective 04/01/14)</td>
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<tr>
<td></td>
<td>• Archived previous policy version OUTPATIENT 033.18</td>
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