



Sleep Apnea Dentists of New England

Medical Guidelines for Oral Device Coverage

Diagnosis with polysomnography (a sleep test) is required and must be reviewed by a physician. To limit the number of patients who qualify for an oral device, the severity of the sleep apnea must be of moderate-severe level (>15 breathing events per hour) consisting of total (apnea) or partial (hypopnea) blockages. Most medical insurers are likely to cover the sleep test and positive airway pressure (CPAP).

Patients with mild sleep apnea (5-15 breathing events per hour) do not automatically qualify for treatment of their sleep disordered breathing, unless they also have an additional diagnosis of hypertension, heart attack, stroke, mood alteration (depression), impaired cognition (memory loss), insomnia or excessive daytime sleepiness. Each company has guidelines as to how each of these additional diagnoses must be verified prior to approval of treatment.

Some HMO organizations allow treatment regardless of the insignificance of breathing disorder with an oral device. These are few and far between.

Convenience Items are not Covered.

Insurance companies will not pay for an oral device that is to be used for the convenience of the patient. This would include a patient who uses CPAP at home but wants an oral device to use when travelling, hiking or camping.

TERMS YOU MUST UNDERSTAND

Indemnity Plan: A health plan that pays a specific amount for any provider you see regardless of network status. This is basically fee-for-service.

PPO: Preferred Provider Organization. This policy allows you to see any provider you wish without the need for a referral. Different fees are paid to in and out-of-network providers. In-network providers get paid at a higher level.

EPO: Exclusive Provider Organization. There is no coverage if you see an out-of-network provider.

HMO: Health Maintenance Organization is an insurance that pays at a higher level if you see an in-network provider and rarely allows out-of network payments. This varies by the plan chosen by your employer.

Balance Billing: The insurance company pays part, the patient pays part, and the in-network doctor writes off the rest. An out of-network doctor does not have to write off any part of the fee. The out-of-network provider will send a bill to the patient for the entire balance due after the insurer pays their portion.

UCR: Usual, Customary and Reasonable. By law, the medical insurance companies must pay their providers a fee that is usual for a covered service. Customarily, this is assumed to be the average fee charged for this service in your area. Some insurance companies set an arbitrarily low UCR so that they force providers to leave the network or much reduce their fees. If your insurer says they will pay a percentage of the fee for an oral device (maybe 80%) they will only pay 80% of their UCR, NOT the fee submitted. Balance billing by the provider may leave the patient with a large balance owed.

The **Commonwealth of Massachusetts** has an Office of Consumer Affairs whose mission is to help prevent an insurance company from taking advantage of its members. If your medical insurer refuses to pay for a covered service or denies payment that was previously authorized, or you have any complaints, you would do well to contact:

Office of Consumer Affairs/Insurance
1000 Washington St. Ste 810
Boston, MA 02118-6200
617-521-7794

**Oral Device
Therapy for the
treatment of
obstructive sleep
apnea is covered
under your
Medical Insurance**

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Medical Insurance

Oral devices to treat obstructive sleep apnea are considered Class 2 medical devices because they treat a recognized medical disease that can only be diagnosed by a physician; therefore, only medical insurers will pay for the cost. This presents a problem since an oral device can only be made by a dentist and most dentists are not allowed to be in-network providers with your medical insurer.

How do medical insurers control access to out-of-network providers?

If you are part of an HMO (Health Maintenance Organization) you can never see a specialist without a referral from your primary care physician. A **referral** is needed for you to see an in-network specialist. An **authorization** is required for you to see a provider who is not contracted with your insurance company. Authorization for treatment is normally required for most dentists who make oral devices for sleep apnea. Authorizations often require submission of paper documents to a central site or a telephone call to a specific department at the insurance company. The insurance company can insist that you see an in-network provider even if they don't have an appropriately-trained dentist in their network.

How do medical insurers control access to a dentist specially trained to make and follow-up oral device therapy for Obstructive Sleep Apnea?

Medical insurance companies contract with providers who are willing to discount their fees in return for an increased number of patients. Because there is a fee discount, medical insurers make it financially rewarding for patients to use in-network providers. Most insurance companies have by-laws that do not allow a dentist to be in-network with that medical insurer unless that dentist is an oral surgeon.

If you call your insurance company and ask if they cover "mouth pieces" the representative will say "no" since the name of an item is not how coverage is determined. It is the billing code that identifies the service. The code for a custom fitted oral device to treat sleep apnea is E0486. You will need to ask if an E0486 is covered under your policy. It would be wise to find out if there is a limit on what they pay and if you have already used some of your benefit.

The representative will suggest that you see an in-network provider, but may not be able to give you the name of a provider who actually does oral device therapy. Be aware, you may be given the name of any oral surgeon in your area.

MEDICARE

Medicare has very rigorous scoring criteria for breathing events but uses conventional guidelines to determine patient qualification. Medicare now contracts with qualified dentists as participating providers, and we are Medicare-approved.

Why Sleep Apnea Dentists of New England?

The dentists at Sleep Apnea Dentists of New England have been treating patients with obstructive sleep apnea longer than any other practice in the Commonwealth of Massachusetts.

We receive in-network coverage from Aetna, Blue Cross of MA (HMO and Indemnity only), Harvard Pilgrim, Medicare, TRICARE, GIC and the VA.

Our knowledgeable staff will attempt to get in-network coverage for patients covered by Tufts Health Plan, CIGNA, United Health Care and other insurers; this is very time consuming and frequently denied by the insurance company. If allowed, it will decrease the patient's out-of-pocket costs.

Letter of Medical Necessity

Your *physician* must fill out and sign a letter that states you require an oral device for medical reasons. This is required by medical insurers prior to authorizing treatment.

Referrals and Authorizations

It is the *patient's responsibility* to obtain all necessary referrals and authorizations for the initial visit.

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Visit us at:

www.SleepApneaDentist.com