

Clinical Policy: Mandibular Advancement Devices

Reference Number: WA.CP.MP.500

Date of Last Review: 11/24

Effective Date: 01/01/25

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

CPAP is considered the first line standard of treatment for sleep apnea and should be the first choice for sleep physicians for adult clients with sleep-disordered breathing and daytime sleepiness with mild to moderate obstructive sleep apnea. Sleep physicians should consider oral appliances rather than no treatment for adults intolerant of CPAP or for whom CPAP is contraindicated.

See also WA.CP.MP.523 – Sleep Apnea Diagnosis and Treatment, for more information on CPAP criteria.

Policy/Criteria

- I. It is the policy Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Billing Guidelines, that custom-made mandibular advancement device (MAD) is considered **medically necessary** when *the requirements in sections A, B, C, D, E, F and G are met*:
 - A. A face-to-face evaluation with a sleep medicine physician prior to sleep testing is completed in an agency-designated center of excellence
 - B. At least one of the following sleep testing criteria for continuous positive airway pressure (CPAP) is met:
 1. Apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) ≥ 15 per hour with minimum of 30 events, or
 2. AHI or RDI ≥ 5 and ≤ 14 events per hour with minimum of 10 events and documentation of either:
 - a. Excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or
 - b. Hypertension, ischemic heart disease or history of stroke, or
 3. AHI or RDI > 30 and either:
 - a. The member is not able to tolerate a positive airway pressure (PAP) device, or
 - b. The treating physician determines that the use of a CPAP device is contraindicated.
 - C. The member has tried and failed the use of CPAP demonstrated by either
 1. Documentation of at least a six month trial period, describing why CPAP failed, or
 2. Reason explaining why CPAP is not the appropriate treatment.
 - D. The device is ordered by the treating provider post-review of the sleep study.
 - E. The device is provided and billed for by a licensed dentist (DDS or DMD) that meets the following:
 1. Certification in dental sleep medicine by a non-profit organization, such as the American Board of Dental Sleep Medicine (ABDSM), or

2. Designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, such as the American Academy of Dental Sleep Medicine (AADSM), or
 3. Recognized continuing education in dental sleep medicine provided by a dental sleep medicine focused non-profit organization or accredited dental school within the last 2 years
- F. The device is titrated in a sleep center by a qualified provider who has experience in titrating the MAD
- G. The member/enrollee has their own teeth (no dentures or partials).
- II.** It is the policy Coordinated Care of Washington, Inc., that *pre-fabricated* mandibular advancement devices (MAD) are **not medically necessary**, including, but not limited to:
- A. Oral occlusal appliances for Temporal Mandibular Joint (TMJ) disorder,
 - B. Tongue retaining devices used to treat Obstructive Sleep Apnea (OSA) and/or snoring,
 - C. All oral appliances used only to treat snoring without a diagnosis of OSA,
 - D. Oral appliances used to treat other dental conditions,
 - E. Oral appliances that require repeated fitting and/or adjustments, beyond the first 90-days, in order to maintain fit and/or effectiveness

Background

This policy is based entirely on Washington State Health Care Authority Billing Guidelines. The agency pays for one medically necessary, custom-made mandibular advancement device per member age 21 or older, every five years.

Coding Implications

The following codes are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Codes that support coverage criteria

HCPCS Codes	Description
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated

Codes that do not support coverage criteria

HCPCS Codes	Description
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable prefabricated

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted. Previously WA.UM.44	06/19	06/19
Minor edits. Reference updated.	03/20	04/20
Annual review. Reference updated.	02/21	03/21
Annual review. Reference reviewed.	02/22	03/22
Annual review. Reference updated.	12/22	01/23
Annual review. Reference reviewed.	12/23	12/23
Annual review. Reference updated.	11/24	11/24

References

1. Washington State Health Care Authority. Sleep Centers Billing Guide.
<https://www.hca.wa.gov/assets/billers-and-providers/Sleep-centers-bg-20240701.pdf>
Revision effective July 1, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

©2017 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.