Billing for the treatment of OSA with oral orthotics:

Obstructive Sleep Apnea is a medical disease. All time and procedures involved in evaluating for or treating OSA is, therefore, generally covered only by the patient’s medical insurance. All claims must be submitted on a HCFA 1500 form printed in the original red or electronically submitted.

Evaluation:
Unlike dentistry, medical codes (CPT) are based on time the provider spends directly with the patient. There are no codes for time an ancillary staff spends with the patient. If periodontal probing and charting is done by a hygienist or dental assistant, the dentist cannot legally bill for the time spent gathering data; the dentist can charge only for the time he/she spends reviewing the charting and evaluating the patient.

The American Medical Association puts out an annual "Current Procedural Terminology CPT" book. The following explanations are abbreviated and from the 2000 edition. An up-to-date CPT code book allows you to have full explanation of the definitions used by insurance companies and physicians for billing services. Be aware that these codes are frequently reviewed and altered and the following list cannot be used as your sole source of billing codes.

Office Consultation: For patients referred by the attending physician (Documentation that the patient was referred by the attending physician is expected to be part of your chart)

99241
It requires these three key components:
- A problem focused history
- A problem focused examination
- Straightforward medical decision making
The physician usually spends 15 minutes face to face with the patient

99242
It requires these three key components:
- An expanded problem focused history
- An expanded problem focused examination
- Straightforward medical decision making
The physician typically spends 30 minutes face to face with the patient

99243
It requires these three key components:
- An expanded problem focused history
- An expanded problem focused examination
- Medical decision making of low complexity
The physician typically spends 40 minutes face to face with the patient

99244
It requires these three key components:
A comprehensive history
A comprehensive examination
Medical decision making of moderate complexity
The physician typically spends 60 minutes face to face with the patient / family

99245
It requires these three key components:
A comprehensive history
A comprehensive examination
Medical decision making of high complexity
The physician typically spends 80 minutes face to face with the patient or family

New Patient Visit: (Not referred by an attending physician)

99201
Requires these three following key components:
A problem focused history
A problem focused examination
Straightforward medical decision making
Physicians typically spend 10 minutes face to face with the patient

99202
Requires these three following key components:
An expanded problem focused history
An expanded problem focused examination
Straightforward medical decision making
Physicians typically spend 20 minutes face to face with the patient

99203
Requires these three following key components:
A detailed history
A detailed examination, and
Medical decision making of low complexity
Usually the physician spends 30 minutes face to face with the patient

99204
Requires these three following key components:
A comprehensive history
A comprehensive examination
Medical decision making of moderate complexity
Usually the physician spends 45 minutes face to face with the patient / family

99205
Requires these three following key components:
A comprehensive history
A comprehensive examination; and
Medical decision making of high complexity
Established Patient / Follow-up Office visit

99211
May not require the presence of the physician / dentist; Typically 5 minutes

99212
Must include at least 2 of the following 3 key components:
- A problem focused history
- A problem focused examination
- Straightforward medical decision making
On average it takes 10 minutes face-to-face between the provider and the patient

99213
Requires two of the three following key components:
- An expanded problem focused history
- An expanded problem focused examination
- Medical decision making of low complexity
On average the provider spends 15 minutes face to face with the patient

99214
Requires at least two of the three following key components
- A detailed history
- A detailed examination
- Medical decision making of moderate complexity
Usually the physician spends 25 minutes face to face with the patient

99215
Requires at least two of the three following key components:
- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity
Usually the physician spends 40 minutes face to face with the patient / family

Oral Orthotic:
S8260: Used by most private medical insurers: Defined as an oral orthotic for the treatment of obstructive sleep apnea
E1399: Used by Medicare (Their medical guidelines will only cover an oral orthotic if the patient has a post-placement polysomnogram that PROVES the orthotic is effective in controlling the OSA. This is bundled with 99002 and is listed as “DME miscellaneous.” Dentists cannot get a DME contract with Medicare (separate from a Medical Provider Contract) only laboratories and actual sales entities qualify. Therefore, only the patient can seek reimbursement from Medicare. All requests require that the patient complete a form 0938-0008 (Also called HCFA-1490S) and provide required documentation. This includes a prescription from the physician of record requesting that an oral orthotic be fabricated, a diagnostic polysomnogram meeting Medicare criteria, and a follow-up polysomnogram proving successful treatment with the orthotic.
21089: Used by BCBS of Illinois (as of 2004) and defined as “unlisted maxillofacial prosthetic procedure.”
21085: Used by Tricare (U.S. Armed Forces Coverage) and defined as "oral surgery splint"

99002: "Handling, conveyance and/or any other service in connection with the implementation of an order involving devices when devices such as orthotics are fabricated by an outside laboratory but which items have been designed and are to be fitted and adjusted by the attending physician."

99002.22: Modified by: "Unusual procedural services: When the service provided is greater than that usually required for the listed procedure (i.e.: 99002), it may be identified by adding a modifier to the usual procedure number. A report is appropriate."

NU: A modifier used by some insurance companies to indicate an appliance that was bought, not rented.

There are codes for radiographs including full mouth series and lateral cephalometric films e.g. 70250. Even though the codes exist, they are rarely considered a ‘covered service’.

**Diagnosis Codes:**

*This list of codes is not guaranteed accurate and should be validates with the appropriate organizations.*

- 780.50 Obstructive Sleep Apnea
- 780.51 Obstructive Sleep Apnea with hyposomnia or insomnia****
- 780.52 Upper Airway Resistance Syndrome
- 780.53 Obstructive Sleep Apnea with hypersomnia
- 780.57 Obstructive Sleep Apnea NEC/ sleep disturbance NEC*****
- 786 Primary snoring
- 786.09 Snoring

Most insurance companies have very strict guidelines as to which diagnosis code is considered a disease, and treatment is therefore covered. Very few, if any, insurance companies will cover treatment for snoring or upper airway resistance syndrome.

It is highly recommended that dental office seek “predetermination of medical necessity” for all oral orthotics from the patient’s insurance company. This will make it easier for the patient to seek reimbursement from his medical insurer if the dentist does not accept insurance. The insurance company will require a letter explaining the treatment to be provided, the pertinent codes and fees involved. They will also want a copy of the polysomnogram reports, a letter of medical necessity from the referring physician and possibly a copy of the dentist’s evaluation notes / letter to the referring physician and an explanation why CPAP is not being used. The majority of insurance companies have an oral surgery/ maxillofacial reviewer who is responsible for determining if the patient meets the guidelines set forth in the insurance companies “Medical Policy for obstructive sleep apnea”(often available on the insurance companies website). If so, then, predetermination will be granted. This does not guarantee payment on the claim. Pre-
certification deals with payments. Always check the policy guidelines for each patient to make sure they have benefit coverage for oral orthotics.

Many patients have an "annual allowance" for DME coverage. If the amount is $1500.00 and the patient also bought a CPAP machine in the same 'contracted year' then, even though you receive predetermination of medical necessity, the claim will not be paid because the patient would have exhausted his annual allowance for DME benefits.

All dentists are considered “out-of-network” medical providers. Some dual degreed (DDS and MD) dentists do have contracts with medical insurance companies, but many do not. Thus, dentists can often request “Gap exception” from an insurance company. If a patient is required to utilize in-network providers for maximum benefit coverage, and the insurance company does not have anyone in-network who can do oral orthotic therapy, then many policies allow the insurance company to reimburse out-of-network providers at in-network rates. This is known as Network Gap or Network Insufficiency. Coverage at the higher rate must be requested by the dental office. Depending on the insurance company and the policy, this may be handled by the Precertification group or by Benefits / claims; who grants this exception may vary within one medical insurance company.

Some employers ask that oral orthotics not be covered under the policies they buy for their employees. The “Big Three Auto” makers write this coverage out off their policies. Note that some medical insurance companies will argue that “orthotics” are not covered by a patient's policies. They are referring to foot orthotics and not oral orthotics for the treatment of OSA. It is common that a representative will absolutely refuse to authorize coverage for oral orthotics and discussion with a supervisor or the medical director may be necessary. You can request a copy of their medical policy on obstructive sleep apnea or find it on the insurance company website. This document will detail what that company defines as treatable disease, and what therapies are covered services.

**Medicare…stands alone:**

Dentists cannot get a DME contract with Medicare (separate from a Medical Provider Contract) only laboratories and actual sales entities qualify. Therefore, if a dentist has a Medical Provider Contract with Medicare, he can file an insurance claim for the medical aspect of the patient visits only; for the DME (oral orthotic) the patient must seek reimbursement from Medicare. Medicare contracts all claims processing to private companies. These regional contractors set up separate contracts with providers. There is no “one” Medicare contract nationwide.

Filling out a HCFA 1500 for Medicare is different from filling out the form to send to a commercial insurer. One local claims contractor has set up a very detailed description of how to correctly fill out claims for Medicare.

Medicare will not prior authorize an oral orthotic for the treatment of obstructive sleep apnea. Medicare also has a very strict definition of obstructive sleep apnea that makes many patients unqualified for treatment. Obstructive sleep apnea increases in severity
and in the number of people it afflicts with increasing age; it also is less likely to be a direct cause of death in an elderly population.

Their medical guidelines will only cover an oral orthotic if the patient has a post-placement polysomnogram that PROVES the orthotic is effective in controlling the OSA. This is bundled with 99002 and is listed as “DME miscellaneous.” All requests require that the patient complete a form 0938-0008 (Also called HCFA-1490S) and provide required documentation. This includes a prescription from the physician of record requesting that an oral orthotic be fabricated, a diagnostic polysomnogram meeting Medicare criteria, and a follow-up polysomnogram proving successful treatment with the orthotic.

Once all of the criteria have been met, the patient must be aware that Medicare usually refuses coverage and the patient will need to appeal the decision of the claim reviewer. Perseverance is the name of the game. Also, reimbursement is at the fee schedule set by Medicare and will not reflect the actual fee charged by the provider.