Priority Health	BILLING POLICY No. 141
Surgical Treatment and Oral Appliances for Sleep Apnea: Obstructive and Central	
Date of origin: Aug 2025	**Review dates: 7/2026**

DEFINITION

Surgical options for sleep apnea are considered when non-invasive treatments fail, and they aim to improve airflow by addressing anatomical obstructions in the airway.

Oral appliances, also called **oral appliance therapy**, treat Obstructive Sleep Apnea (OSA). They hold the mouth in a position that makes sure there is enough airflow. These devices aid in better breathing and reduce the number of OSA related wake ups.

MEDICAL POLICY

91333 Sleep Apnea: Obstructive & Central
91110 Durable Medical Equipment

Related Billing Policy:

020 Positive Airway Pressure
050 DME POS

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Medical records must be legible, meet coverage criteria, and be available upon request. They should include:

- Relevant patient history
- Counseling on procedure risks and benefits
- CPAP trial documentation for sleep apnea under a trained physician
- Follow-up evaluations by a sleep disorder specialist after surgery

Missing any of these elements may result in claim denial.

Reimbursement specifics

Coverage for oral appliance devices for OSA is only approved if:

- The test is FDA-approved as a diagnostic device.
- Results meet coverage criteria for the date of service.
- The test is ordered by the treating practitioner.
- The test is conducted by a qualified provider following state regulations.

Non-covered items (considered dental, not DME) include:

- TMJ oral appliances
- Tongue retaining devices for OSA/snoring
- Appliances for snoring without OSA diagnosis
- Devices for other dental conditions
- Appliances needing adjustments beyond 90 days

Oral Appliance Replacement Guidelines:

- Oral appliances can be replaced after 5 years of use.
- Early replacement is allowed only if the device is lost, stolen, or irreparably damaged (e.g., accident, fire, flood).
- Normal wear-and-tear before 5 years is not covered for replacement.

Billing details

Authorization is not required:

- Home sleep testing
- CPAP supplies and oral appliances, unless DME/P&O dollar threshold exceeded (greater than

Oral appliances are used to maintain an open airway during sleep, primarily for treating **Obstructive Sleep Apnea (OSA)**. These include:

- **Mandibular advancement devices**: Move the lower jaw forward
- **Tongue positioning devices**: Reposition the tongue using various mechanisms.

There are two types of oral appliances:

- **Prefabricated (E0485)**: Mass-produced and modified for individual use.
- **Custom fabricated (E0486)**: Made specifically for an individual using dental impressions or digital imaging.

To qualify for **E0486 coding**, custom mandibular advancement devices must meet strict criteria, including:

- Fixed mechanical hinge
- Adjustable mandibular protrusion
- Retention of settings and position during sleep
- No ongoing dental adjustments beyond 90 days

Devices not meeting these criteria or used for snoring without an OSA diagnosis must be coded as **A9270 (non-covered)**. TMJ treatment appliances are coded for **D7880** and not billed to DME MACs.

Treating practitioners must document the in-person clinical evaluation in a detailed narrative, consistent with standard charting. The evaluation typically includes:

- **History**: Symptoms of sleep-disordered breathing (e.g., snoring, daytime sleepiness, apneas), symptom duration, and a validated sleep scale like the Epworth Sleepiness Scale.
- **Physical Exam**: Focused cardiopulmonary and airway assessment, neck circumference, and BMI.

Coding specifics

Surgical Treatment of Obstructive Sleep Apnea

The treatment and procedure codes listed below are provided for informational purposes only. Their inclusion or omission does not guarantee member coverage or provider reimbursement. To determine whether these services are covered for a specific member, please consult the member's benefit contract in effect at the time of service.

21110- Application of interdental fixation device for conditions other than fracture of dislocation, includes removal
21141- Reconstruction midface, lefort I; single piece, segment movement in any direction
21145- Reconstruction midface, Lefort I; single piece, segment movement in any direction, requiring bone grafts
21196- Reconstruction of mandibular rami and/or body, sagittal split: with internal rigid fixation
21199- osteotomy, mandible, segmental; with genioglossus advancement
21685- hyoid myotomy and suspension
30140- submucous resection inferior turbinate, partial or complete any method
30802- ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method
31600- Tracheostomy, Planned
31610- Tracheostomy, Fenestration procedure with skin flaps

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

KX Modifier – Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)

GA, GY, GZ Modifiers – Per CMS local coverage determinations, one of these modifiers are required for claim processing. Please review applicable LCD for additional guidelines. (Medicare)

EY - No physician or other licensed health care provider order for this item or service

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy

Place of Service Codes | CMS

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENES

Aetna- Obstructive Sleep Apnea in Adults - Medical Clinical Policy Bulletins | Aetna

United Health Care Obstructive and Central Sleep Apnea Treatment – Commercial and Individual Exchange Medical Policy

CMS- Article - Billing and Coding: Surgical Treatment of Obstructive Sleep Apnea (OSA) (A56905)

CMS- Article - Oral Appliances for Obstructive Sleep Apnea - Policy Article (A52512)

Anthem - SURG.00129 Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding

accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
July 24, 2026	Reviewed. No changes