SomnoGuard® Oral Appliance Administration Assistant

Representative:
Tim Cline
(214) 906-8721
entman3@sbcglobal.net

Reference Certificate of Medical Necessity

OSA Severity Index:

Insurers require copy of the Sleep Study to establish Medical Necessity

AHI/RDI*	Severity	Notes
<5	Not clinically significant - snoring	Not covered- cash for snoring
5 ≥ 14	Mild	Often requires comorbidity**
15 ≥ 29	Moderate	Typical covered 1st line option
≥ 30	Severe	CPAP first or conjunctive therapy

* If both AHI and RDI are provided on Sleep Study, insurers typically reference **AHI** for determination of medical necessity.
** Mild OSA may require documentation of associated comorbidity:
Epworth Score>10, Loud Disruptive Snoring, Hypertension, history of Stroke/heart attack, cognitive dysfunction, etc.

Coding: One of three codes (Depending upon Medical Policy)

Document preferred code in your area (varies) **HCPCS: E0485** **Service: S8262** **CPT: 21085**

Medicare only covers Custom Appliances under HCPCS E0486. Can offer patient cash price with signed ABN. Contact customer service for sample ABN.

Code	E0485	21085	S8262	Notes (amend as experienced) (Reimbursed amount for example)
Aetna	✓		✓	AHI>15 requires comorbidity, no Pre-auth Required for Participating Providers
BCBS of TX	✓	✓	✓	
UHC	✓		✓	
Cigna			✓	

866-720-8080

Services considered not Medically Necessary for any reason should be presented with a cash option (Price:_______) as the Somnoguard is one of the most effective and cost effective treatment options. Once considered not covered, you are free to provide service to your patient without implication and patient may actually minimize out of pocket expense.

Certificate of Medical Necessity

SomnoGuard®
Oral Appliance
Prescription Form

Patient (Last, First, MI)_______________________________ Today's Date:________________________

Shipping Address:___________________________________ Date of Birth (m/d/yy) ________________

City:____________________ St:_______ Zip:____________ Home Phone ________________________ ( )

Cell Phone _________________________ ( )

Insurer:_________________ ID#:______________________ Work Phone ________________________ ( )

SomnoGuard® Oral Appliance ☑ Please Specify	Prescribing Physician Information
☐ SomnoGuard® SP Soft Two Part, Two piece Mandibular Advancement Device 1mm-Incremental Advancement Positioners included. FDA# K121761. For Snoring and Mild/Moderate OSA. ☐ SomnoGuard® AP Two Part, Two piece Mandibular Advancement Device Micro-adjustment Titration, free lateral movement, mouth breathing, Custom Fitted Oral Appliance. FDA# K061688. For Snoring and Mild/Moderate OSA.	Name/Title____ Address:____ City:_______________________________ ST:_______________ Zip:________________ Phone: __________________________ Fax:____________________________ NPI:_________________________________

Primary Diagnostic ICD-9 Code (check)

Insurance submission code: HCPCS E0485/CPT 21085/S8262

☐ 327.23 Obstructive Sleep Apnea (Adult & Pediatric)	☐ 780.57 Unspecified Obstructive Sleep Apnea	☐ 786.09 Snoring

Indication ☑

☐	Snoring
☐	Mild OSA: AHI/RDI: ___ Documented by PSG/HST: ________ OSA Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Moderate OSA: AHI/RDI: ___ Documented by PSG/HST: ________ OSA Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Severe OSA: AHI/RDI: ___ Documented by PSG/HST: ________ CPAP Intolerance: _____ days OSA Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Severe OSA: AHI/RDI: ___ Documented by PSG/HST: ________ Lower PAP pressure: ____cm Complications: ☐EDS ☐Hypertension ☐Epworth Score_____ ☐Cognitive Dysfunction (attach Sleep Study Results and interpretation)
☐	Mild/Moderate/Severe OSA, Secondary Therapy: ☐ Travel ☐ Restrictions to consistent CPAP use:_______________________________________

______________________________ ______________________________ __________

Physician Name Physician Signature Date