MEDICAL POLICY

Medical Policy Title	**Medical Management of Obstructive Sleep Apnea (OSA)**
Policy Number	**1.01.07**
Current Effective Date	**October 22, 2026**
Next Review Date	**October 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Oral appliances (OAs) are **medically appropriate** for the treatment of obstructive sleep apnea (OSA) when **ALL** of the following are met:

A. Individual meets **any** of the following:

1. The individual cannot tolerate, or refuses continuous positive airway pressure (CPAP) therapy; **or**
2. The physician determines that the use of positive airway pressure (PAP) therapy is contraindicated;

B. Individual meets **any** of the following indication severity specific criteria:

1. Mild OSA diagnosis documented with a Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) ≥ 5 and ≤ 14, confirmed by a sleep study (e.g., PSG or home sleep study); with at least **any** of the following indications:
   a. Hypertension;
   b. Heart disease;
   c. Stroke;
   d. Excessive daytime sleepiness;
   e. Impaired cognition;
   f. Mood disorders; **or**
   g. Insomnia;
2. Moderate OSA diagnosis documented with a AHI or RDI ≥ 15 and < 30 confirmed by a sleep study; **or**
3. Severe OSA diagnosis documented with a AHI or RDI ≥ 30, confirmed by a sleep study.

II. OAs are considered **not medically necessary** for **ANY** of the following indications, including but not limited to:

A. Upper Airway Resistance Syndrome (UARS) with or without snoring and without a diagnosis

of OSA;

B. Primary snoring;

C. Temporomandibular joint disorders (TMJD);

D. Central sleep apnea;

E. Prefabricated or non-custom OAs.

III. Daytime neuromuscular electrical stimulation devices (e.g., eXciteOSA) are considered **investigational** for the treatment of OSA.

IV. Sleep positioning trainer use with or without vibration is considered **investigational** for the treatment of positional OSA.

V. Replacement of a medically necessary oral appliance due to misuse or neglect (e.g., lost, or misplaced) is **ineligible for coverage**.

VI. Replacement of a medically necessary OA is **eligible for coverage** after five (5) years, unless there is documented evidence of device failure or a clinically significant change in the patient's condition that necessitates earlier replacement (e.g., tooth loss or major dental reconstruction).

RELATED POLICIES

Corporate Medical Policy

1.01.06 Continuous Positive Airway Pressure (CPAP) and Auto -Adjusting Positive Airway Pressure (APAP) Devices

7.01.41 Surgical Management of Sleep Disorders

11.01.03 Experimental or Investigational Services

11.01.17 Temporomandibular Joint Disorders (TMJD)

POLICY GUIDELINE(S)

I. Attempts at behavioral modifications and lifestyle changes (e.g., good sleep hygiene, weight loss, avoidance of alcohol consumption in evening, smoking cessation, sleep position change, treatment of nasal congestion) for individuals with UARS and sleep apnea should be an integral part of the treatment regimen for sleep-disordered breathing.

II. The decision for the use and fabrication of an OA should be made by a sleep medicine physician (e.g., somnologist or sleep specialist; ear, nose, and throat [ENT] specialist) or by an experienced dentist/orthodontist in collaboration with a sleep specialist.

III. All impressions, try-ins, and adjustments and repairs are inclusive to the lifetime of the appliance after approval of the device.

DESCRIPTION

Sleep related breathing disorders are characterized by abnormal respiration during sleep, which may

or may not also occur during wakefulness. These abnormalities can include pauses in breathing, shallow breathing, or reduced airflow, often leading to fragmented sleep and reduced oxygen levels. Other symptoms can include loud snoring, gasping, choking during sleep, morning headaches, dry mouth, daytime fatigue, sleepiness, mood changes, and cognitive issues. There are several types of sleep related breathing disorders. OSA (the most common type) causes physical blockage of the upper airway typically due to relaxed throat muscles during sleep. OSA in an adult is defined as recurrent episodes of complete or partial obstruction of the upper airway leading to reduced or absent breathing during sleep for greater than 10 seconds.

Primary snoring (also called simple snoring or non-apneic snoring) is defined as habitual snoring in the absence of obstructive sleep apnea — specifically, an apnea-hypopnea index (AHI) <5 events per hour on polysomnography, without significant oxygen desaturation, frequent arousals, or gas exchange abnormalities.

Upper airway resistance syndrome (UARS) is a milder form of obstructive sleep related breathing. The airway narrows but does not fully close. This can cause sleep fragmentation and fatigue.

Central sleep apnea occurs when the brainstem, which regulates breathing, does not respond appropriately to changes in carbon dioxide levels in the blood. This results in reduced or absent respiratory effort, leading to pauses in breathing during sleep. Central apneas are often linked to heart failure or neurological conditions. The central apneas occur without any airway obstruction.

Sleep related hypoventilation disorders causes inadequate breathing during sleep which can lead to high carbon dioxide levels. Hypoventilation disorders are common in obesity, neuromuscular disorders, or medication use.

Sleep related hypoxemia is sustained low oxygen levels during sleep without elevated carbon dioxide. Often due to lung diseases or other medical conditions.

Oral Appliances (OAs)

OAs can be prefabricated, ready-made, or custom fitted device worn in the mouth during sleep to treat OSA and snoring. They work by repositioning the jaw, tongue, or soft tissues to keep the airway open, allowing for uninterrupted breathing throughout the night. The most common type of oral appliance is the mandibular advancement device (MAD), which is custom made for each individual and adjustable to allow a dentist to modify the degree of jaw advancement as needed. The goal is to achieve the most comfortable and effective position for the individual. Examples of custom oral appliances include tongue-retaining devices, non-adjustable mandibular repositioning devices (MRDs), and adjustable MRDs. These appliances may be used as an alternative to other medical (e.g., CPAP and surgical (e.g., Uvulopalatopharyngoplasty) interventions.

AIO BREATHE (AIOMEGA LLC, Texas) is a lightweight MAD that increases airway size and repositions the jaw to keep the airway more open during sleep. It is recommended for mild to moderate sleep apnea and snoring.

ProSomnus EVO PH (ProSomnus Sleep Technologies), sleep and snore devices use medical grade polymers and hinge components to reposition and stabilize the jaw during sleep. The OA causes an increase in the pharyngeal space, reducing the risk of upper airway collapse. The device is

recommended for snoring and to treat mild to moderate OSA.

iNAP (Somnics Health, Inc.) uses gentle suction to move the tongue forward. No mask or headgear is required.

Vivos (Vivos Therapeutics, Inc) OAs are noninvasive, custom-made devices designed to treat OSA and snoring. They function by repositioning the hard and soft tissues of the airway to enhance airflow and improve upper airway function. The Vivos System gradually remodels the upper airway and jaw structure over time to address the underlying anatomical causes of OSA. Recently, the United States Food and Drug Administration (FDA) approved Vivos OAs the treatment of severe OSA.

Neurostimulators

eXciteOSA is an FDA approved daytime therapy designed to treat snoring and mild OSA by strengthening tongue muscles through neuromuscular electrical stimulation (NMES). It is intended for adults aged 18 and older with an AHI less than 15. The device consists of a mouthpiece with four electrodes, two above and two below the tongue that are connected to a control unit via USB. It delivers electrical pulses to stimulate both intrinsic and extrinsic tongue muscles. This stimulation strengthens the muscles, helping to prevent the tongue from collapsing backward during sleep. As a result, it supports airway patency and contributes to the reduction of snoring and apnea events.

Positional Sleep Aids

Positional sleep aids encourage sleeping positions that may help with snoring, sleep apnea, back pain, and acid reflux. There are many different types of positional sleep aid devices such as pillows, noodles or devices that can be placed on the body that vibrate or inflate when in the supine sleep position.

SUPPORTIVE LITERATURE

Oral Appliances (OAs)

Gupta et al (2026) conducted a systematic review and meta-analysis evaluating the effectiveness of mandibular advancement devices (MADs) compared with CPAP and sham/control interventions in adults with OSA. Eight randomized controlled trials involving 642 participants were included. The analysis found that CPAP was significantly more effective than MAD therapy in reducing the AHI, with patients using MADs demonstrating higher residual AHI values (mean difference [MD] = 11.83 events/hour; 95% CI: 6.61-17.04). In comparison with sham or control devices, MAD therapy significantly improved AHI (MD = 15.78 events/hour; 95% CI: 8.43-23.13), although heterogeneity remained high (I^2 = 86.47%). Secondary outcomes were variable but generally favored MAD treatment. Overall, the findings indicate that CPAP remains the most effective treatment for reducing respiratory events in OSA, while MADs provide a beneficial alternative for patients who are unable to tolerate or consistently adhere to CPAP therapy. The results should be interpreted with caution due to the considerable heterogeneity among studies and the limited amount of sham-controlled evidence available.

Hamoda et al (2025) conducted a multicenter, double-randomized trial comparing CPAP and mandibular advancement splints (MAS) in treatment-naïve adults with mild-to-severe OSA to evaluate

adherence, effectiveness, and long-term treatment patterns. A total of 81 participants were enrolled, with 73 completing the crossover phase and included in the intention-to-treat analysis. During the crossover phase, objective adherence was significantly higher with MAS than with CPAP, averaging 6.0 versus 5.3 hours per night, respectively, a difference of 0.7 hours per night. However, CPAP demonstrated superior efficacy in reducing respiratory events, with a mean difference in AHI reduction of 10.4 events per hour favoring CPAP. Both therapies produced substantial improvements in patient-centered outcomes, including symptoms and quality of life measures, resulting in comparable overall clinical effectiveness. During the six-month observational phase, more than half of participants (55%) chose to alternate between CPAP and MAS therapy, suggesting that access to both treatment options may enhance long-term disease management. The findings indicate that while CPAP remains the most efficacious treatment for reducing OSA severity, the higher adherence observed with MAS may offset some of this advantage, making both therapies similarly effective from a patient-centered perspective and supporting the use of combined treatment strategies to improve long-term OSA management.

Beri et al (2023) evaluated the effectiveness of OA therapy in treating OSA, focusing on the use of mandibular advancement devices (MADs) and tongue retaining devices (TRDs). The study used the AHI as the primary outcome measure. The inclusion criteria focused on adults with an AHI greater than 5, treated with MAD or TRD, and compared it to CPAP therapy. The analysis was based on a systematic review and meta-analysis of six randomized controlled trials conducted between 1998 and 2021. OAs significantly improve AHI compared to baseline (Mean Difference = 13.40; 95% CI). CPAP outperformed OA in reducing AHI (Mean Difference = 8.40; 95% CI). TRDs showed comparable results to MADs in some studies. Researchers concluded that MADs are effective alternatives for patients with mild to moderate OSA, especially those that are intolerant to CPAP.

Rossi et al (2021) conducted a systematic review of 17 randomized controlled trials (RCTs) to assess the clinical effectiveness of OAs in treating OSA. The review included RCTs with at least 50 participants, comparing OAs to CPAP, placebo, surgery, or other interventions. Findings showed that OAs significantly reduced both the AHI and the Oxygen Desaturation Index (ODI), including in some individuals with severe OSA. Custom-fitted, titratable devices were found to be more effective than non-custom or non-titratable alternatives. While CPAP generally achieved greater reductions in AHI, OAs were associated with higher patient compliance and better tolerability. In cases of mild to moderate OSA, some studies showed that OAs were non-inferior to CPAP. Additionally, improvements in daytime sleepiness (Epworth Sleepiness Scale), snoring, and quality of life were observed, although these outcomes varied across studies.

Electrical Stimulation Appliances

The current body of evidence supporting non-surgical neuromuscular electrical stimulation for OSA remains limited. High-quality data demonstrating its safety and clinical efficacy are lacking. Well-designed, controlled studies are needed to evaluate its therapeutic effectiveness, safety profile, and long-term outcomes. Two cohort studies (Kotecha et al (2021) and Baptista et al (2021)) studied habitual snorers who were treated with eXciteOSA. Both studies reported a reduction in snoring time measured by the Watch-PAT device and bed-partner-reported snorting was also decreased. A reduction in AHI was noted in those participants with mild OSA in the Kotecha study but there was no

clinically significant reduction in AHI reported in the Baptista study. Both the Epworth Sleepiness Scale (ESS) and Pittsburgh Sleep Quality Index (PSQI) test showed improvements as reported by the participants as well as the bed partners. These studies suggest that daytime tongue stimulation may improve snoring, but the effect on OSA is uncertain.

PROFESSIONAL GUIDELINE(S)

The 2015 clinical practice guidelines jointly issued by the American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) (Ramar et al) reported new guidelines to update and replace previous recommendations for the use of OAs in the treatment of OSA and snoring. The recommendations are as follows:

- "Sleep physicians should prescribe oral appliances instead of offering no treatment for adults seeking help for primary snoring without obstructive sleep apnea."
- "When treating adults with OSA sleep physicians should recommend that a qualified dentist provide a custom, adjustable OAs rather than a non-custom device."
- "For adults with obstructive sleep apnea who cannot tolerate CPAP or prefer another option, sleep physicians should consider prescribing OA instead of leaving the condition untreated."
- "Qualified dentists should monitor patients using OAs for OSA to detect and minimize dental side effects or bite changes, rather than providing no follow-up."
- "Sleep physicians should conduct follow-up sleep studies to confirm or improve the effectiveness of OA therapy, rather than relying on follow-up without testing."

The American Academy of Dental Sleep Medicine (AADSM) released an updated position statement in October 2022, on the use of OAT for the treatment of OSA. Some of the recommendations include:

- "OAT is an effective treatment for both OSA and snoring, and should be considered a first-line therapy, particularly for patients who are intolerant of CPAP therapy."
- "Patient evaluation and appliance fitting should be conducted by qualified dentists trained in dental sleep medicine."
- "Patients should be offered a trial of OA or PAP therapy prior to considering surgical interventions for OSA."

The 2021 National Institute for Health and Care Excellence (NICE) Clinical Guidelines for Diagnosis and Management of Obstructive Sleep Apnea/Hypopnea Syndrome (OASAHS), Obesity Hypoventilation Syndrome (OHS) and Chronic Obstructive Pulmonary Disease with OSAHS (COPD-OSAHS overlap syndrome) in people over 16 years of age recommends:

- "Offering fixed-level CPAP in those with mild OSA when symptoms affect quality of life (QOL) and usual daytime activities if lifestyle changes alone have been unsuccessful or are considered inappropriate."
- "APAP as an alternative to fixed-level CPAP in those unable to tolerate CPAP."
- "In individuals who cannot tolerate or refuse CPAP, they recommend offering a customized

mandibular advancement device."

- "In individuals with moderate to severe OSA, CPAP is recommended as a treatment option, with APAP offered as an alternative in those unable to tolerate CPAP."
- "A customized mandibular advancement device may be used if an individual refuses PAP or is unable to tolerate PAP."
- "A positional modifier may be considered for those with mild to moderate positional OSA if other treatments are unsuitable or not tolerated, but this should not be a first-line treatment option."

REGULATORY STATUS

The United States Food and Drug Administration (FDA) regulates oral appliances as medical devices. All oral appliances including related components require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: https://www.fda.gov/medical-devices [accessed 2026 Jul 17]

The FDA lists the most serious type of medical device recalls as well as early alert communications about corrective actions being taken by companies that the FDA believes are likely to be the most serious type of recalls. Available from: Medical Device Recalls | FDA [accessed 2026 Jul 17]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
Not Applicable	

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CDT Codes

Code	Description
D9947	Custom sleep apnea appliance fabrication and placement
D9948	Adjustment of custom sleep apnea appliance
D9949	Repair of custom sleep appliance

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HCPCS Codes

Code	Description
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment
E0490 (E/I)	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote
E0491 (E/I)	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply
E0492 (E/I)	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application
E0493 (E/I)	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply
E0530 (E/I)	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility

ICD10 Codes

Code	Description
F51.8	Other sleep disorders not due to a substance or known physiological condition
G47.00-G47.09	Insomnia (code range)
G47.10-G47.19	Hypersomnia (code range)

Code	Description
G47.20-G47.29	Circadian rhythm sleep disorder (code range)
G47.30-G47.39	Sleep apnea (code range)
G47.69	Other sleep related movement disorders
G47.8-G47.9	Other and unspecified sleep disorder (code range)

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Oral Appliances for Obstructive Sleep Apnea (LCD L33611) [accessed 2026 Jul 17]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.

- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
10/18/01, 03/21/02, 03/20/03, 03/25/04, 04/28/05, 02/23/06, 02/22/07, 02/28/08, 02/26/09, 02/25/10, 02/24/11, 02/27/12, 02/28/13, 02/27/14, 02/26/15, 02/25/16, 04/27/17, 02/22/18, 08/22/19, 10/22/20, 10/28/21, 07/21/22, 08/17/23, 08/22/24, 10/16/25, 10/22/26	
Date	**Summary of Changes**
10/22/26	• Annual review. Intent to policy is unchanged.
10/16/25	• Annual review. Changed policy title to Medical Management of Obstructive Sleep Apnea (OSA). Added new indications for OAs for OSA. Added not medically necessary criteria for the treatment of snoring, central apneas, prefabricated/non-custom oral appliances, and sleep positioning trainers. Updated the replacement time period of medically necessary oral appliance from two (2) years to five (5) years. New codes added to the policy (D9947,D9948, D9949 and E0530).
01/01/25	• Summary of changes tracking implemented.
10/18/01	• Original effective date