

September 17, 2021

OFFICERS

Raman Malhotra, MD
President

Jennifer L. Martin, PhD
President-Elect

Kannan Ramar, MD
Past President

James A. Rowley, MD
Secretary/Treasurer

DIRECTORS

Fariha Abbasi-Feinberg, MD

R. Nisha Aurora, MD, MHS

Vishesh Kapur, MD

David Kuhlmann, MD

Eric Olson, MD

Carol L. Rosen, MD

Anita Shelgikar, MD, MHPE

Lynn Marie Trotti, MD, MSc

Steve Van Hout
Executive Director

United Healthcare

SENT VIA EMAIL: mary_weber@uhc.com

RE: UnitedHealthcare Commercial Medical Policy for Obstructive Sleep Apnea Treatment (Policy Number 2021T0525DD)

Dear Ms. Weber,

I am contacting you on behalf of the American Academy of Sleep Medicine (AASM), a professional society that represents over 10,000 sleep medicine clinicians and sleep centers and is dedicated to advancing sleep care and enhancing sleep health to improve lives. We wanted to provide feedback regarding the UnitedHealthcare commercial medical policy for obstructive sleep apnea treatment (Policy Number 2021T0525DD) that became effective July 1, 2021.

We appreciate that much of the UnitedHealthcare policy aligns with the most current evidence-based [AASM clinical practice guidelines](#) and the [AASM Scoring Manual](#), including the definitions being used throughout the policy. However, there are two additions in the required clinical information for oral appliance therapy section that we would like to comment on:

The policy previously included requiring documentation of a “clinical evaluation by a qualified physician trained in sleep medicine,” however, the updated policy requires documentation of the “most recent face-to-face encounter with prescribing physician, when applicable including face-to-face evaluation by a qualified physician (MD or DO) trained in sleep medicine.” The [Clinical Practice Guideline for the Treatment of Obstructive Sleep Apnea and Snoring with Oral Appliance Therapy](#) indicates that a sleep physician should prescribe oral appliance therapy.¹ A physician trained in sleep medicine would be able to rule out other comorbid sleep disorders and select the most appropriate treatment option based on the patient’s individual circumstances, medical history, and preferences. The policy should also be expanded to cover telemedicine encounters, which reduce barriers to health care access and make seeing their provider more convenient for patients who may otherwise not seek care.²

Recommended revision: Documentation of most recent face-to-face or telemedicine encounter with a qualified physician (MD or DO) board-certified or board-eligible in sleep medicine.

In addition, the required clinical information for E0486 in the updated policy now states that the prescription from the physician must include the oral appliance make, model and price and rationale for selection of specific device and accessories. We applaud UnitedHealthcare for requiring documentation of a price quotation, which aligns with the transparency that is being called for across the healthcare system. We agree that it is important for patients to be provided clear, accessible pricing information about the items and services that are being recommended as part of their care in order for them to make the best-informed decisions about the treatment and management of their sleep disorder. However, providing the appliance make, model, and price and rationale for device and accessory selection is beyond what a sleep physician would normally include when prescribing oral appliance therapy. Although the [*Clinical Practice Guideline for the Treatment of Obstructive Sleep Apnea and Snoring with Oral Appliance Therapy*](#) indicates that a sleep physician should prescribe oral appliance therapy, the guideline goes on to state that it is suggested that a qualified dentist* use a custom, titratable appliance for treatment.¹ Qualified dentists are trained to understand the structure of the oral cavity, maxillofacial area, and the adjacent and associated structures, which helps determine if the patient is a suitable candidate for oral appliance therapy, and if so, which oral appliance is most appropriate for the patient.

Selecting an appropriate appliance ensures that patients receive the appliance that will effectively treat their obstructive sleep apnea, provide maximum comfort, minimize side effects, and maximize compliance. When determining the appropriate make and model of an oral appliance, qualified dentists consider several factors. Qualified dentists evaluate the health and stability of every tooth; the angle, alignment and contours of each tooth; the shape of the arch; and how the lower and upper jaws align to select a device that has the appropriate materials and retention to ensure that the appliance can effectively move and keep the jaw in the appropriate position throughout the night to treat the obstructive sleep apnea, as well as maximize comfort and minimize side effects to ensure compliance. In addition, although all oral appliances move the jaw forward, the retention mechanism, size of appliance, material used, and where and how the forces of the appliance interact with the teeth and tongue are all factored into the decision-making process.

Qualified dentists are, therefore, best suited to determine the specific custom, titratable oral appliance that is most appropriate for a patient that is prescribed this treatment, as opposed to the physician making these determinations when writing the prescription. We recommend that documentation of the ‘equipment make, model, and price quotation’ and ‘rationale for selection of specific devices and accessories’ be provided by the qualified dentist, as opposed to be included in the written order from the physician.

Recommended revision: Documentation of equipment make, model, price quotation, and rationale for selection of specific device and accessories should be obtained from a qualified dentist.

Thank you for your consideration of these comments. The AASM appreciates UnitedHealthcare's efforts to create evidence-based policies so that patients with sleep disorders receive the highest quality of care from the appropriate providers. We have also appreciated being able to share feedback on draft UnitedHealthcare policies related to sleep medicine, and welcome the opportunity, in the future, to provide feedback on proposed revisions to any current policies related to sleep. Please feel free to contact Diedra Gray, AASM Director of Health Policy, at dgray@aasm.org or 630-737-9700, for additional information or clarifications.

Sincerely,

Raman Malhotra, MD
AASM President

cc: Steve Van Hout
Sherene Thomas
Diedra Gray

REFERENCES:

1. Ramar K, Dort LC, Katz SG, Lettieri CJ, Harrod CG, Thomas SM, Chervin RD. Clinical practice guideline for the treatment of obstructive sleep apnea and snoring with oral appliance therapy: an update for 2015. *J Clin Sleep Med* 2015;11(7):773–827.
2. American Academy of Sleep Medicine. Sleep Telemedicine Implementation Guide 2. https://j2vjt3dnbra3ps7ll1clb4q2-wpengine.netdna-ssl.com/wp-content/uploads/2021/08/Sleep_Telemedicine_Implementation_Guide_2.pdf. Accessed September 7, 2021.

* As defined in the 2015 clinical practice guideline, qualified dentists should have a valid state license and proof of liability coverage and possess additional training or experience in this area of care. Although not all-inclusive, desirable qualifications include that the dentist have at least one of the following: certification in dental sleep medicine by a non-profit organization, designation as the dental director of a dental sleep medicine facility accredited by a non-profit organization, or a minimum of 25 hours of recognized continuing education in dental sleep medicine (e.g., American Dental Association Continuing Education Recognition Program [ADA CERP] or Academy of General Dentistry Program Approval for Continuing Education [AGD PACE]) provided by a dental sleep medicine focused non-profit organization or accredited dental school in the last two years.¹