MEDICAL POLICY

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Medical Policy Title	**Non-Surgical Management of Sleep Disorders**
Policy Number	**1.01.63**
Current Effective Date	**February 15, 2027**
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)

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

Initial 90-day Trial

I. CPAP and APAP are considered **medically appropriate** for **ANY** of the following indications:
   A. Adults with obstructive sleep apnea (OSA) who meet **ONE** of the following indications:
      1. Polysomnography (PSG) or home sleep testing (HST) results documenting an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) of >5 (five), and <15 respiratory events per hour and ONE of the following associated symptoms:
         a. Symptoms of OSA (e.g., excessive daytime sleepiness, impaired cognition, insomnia); **or**
         b. Documented cardiovascular diseases, including hypertension, ischemic heart disease, or history of stroke; **or**
      2. PSG or HST results document an AHI or RDI of ≥15 respiratory events per hour;
   B. Children <18 years with OSA who meet **ALL** of the following indications: (90-day continuation review is **not** required for pediatric members.)
      1. **Any** of the following indications:
         a. Failure of adenotonsillectomy to relieve OSA symptoms;
         b. A contraindication to surgical intervention;
         c. Nonsurgical approach is strongly preferred; **and**
      2. PSG results document **Either** of the following:
         a. AHI or RDI of ≥5 and exhibits OSA symptoms;
         b. AHI or RDI within normal ranges and the individual exhibits OSA symptoms (e.g., excessive daytime sleepiness, impaired cognition, insomnia) and **any** of the following:

i. Child exhibits episodes of hypercarbia based on end-tidal CO_2 measurements >53 mm Hg;

ii. End-tidal CO_2 is >50 mmHg for 10 to 24% of the sleep time.

Continuation of Use (Past 90-day Trial)

II. Continuation of coverage after the 90-day trial is **medically appropriate** when **BOTH** of the following have been demonstrated. (See Policy Guidelines for Failure of Compliance)

A. Improved AHI and symptom resolution during trial;

B. Compliance has been demonstrated (e.g., defined by using the device for 70% of the nights, for four (4) or more hours per 24-hour period, during a consecutive 30-day period).

III. CPAP is **not medically necessary** for the treatment of snoring without accompanying OSA.

Oral Appliances (OAs)

IV. OAs are **medically appropriate** for the treatment of OSA when **ALL** of the following are met:

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

1. The individual cannot tolerate or refuse CPAP therapy; **or**
2. The physician determines that the use of PAP therapy is contraindicated;

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

1. Mild OSA diagnosis documented with a AHI or 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.

V. Oral Appliances (OAs) are considered **not medically necessary** for **ANY** of the following indications, including but are 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

VI. Non-surgical management for sleep disorders are considered **investigational**, including but not limited to **EITHER** of the following:

A. Daytime neuromuscular electrical stimulation devices (e.g., eXciteOSA);

B. Sleep positioning trainer with or without vibration.

VII. 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).

Durable Medical Equipment (DME) Repair

VIII. Repair of a medically necessary non-surgical sleep disorder DME or components not under warranty will be considered **medically appropriate** when the following criteria are met:

A. Physician documentation includes **ALL** the following:

1. date of DME initiation;
2. manufacturer warranty information, if applicable;
3. attestation that the patient has been compliant with the use of the DME and will continue to benefit from the use of the DME;

B. The DME is no longer functioning adequately; and **BOTH** of the following criteria are met:

1. inadequate function interferes with activities of daily living; and
2. repair is expected to make the equipment fully functional (as defined by manufacturer).

IX. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

DME Replacement

X. Replacement of a medically necessary non-surgical sleep disorder DME or components not under warranty will be considered **medically appropriate** when **EITHER** of the following criteria are met:

A. The DME is no longer functioning adequately and has been determined to be non-repairable, or the cost of the repair is in excess of the replacement cost;

B. There is documentation that a change in the patient's condition makes the present unit non-functional and improvement is expected with a replacement unit.

XI. The replacement of a properly functioning non-surgical sleep disorder DME, its components or accessories are considered **not medically necessary**. This includes, but is not limited to, replacement desired due to advanced technology or to make the DME more aesthetically pleasing;

XII. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

XIII. Accessories or components for non-surgical sleep disorder DME that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan.

Device Repair

XIV. Repair of a medically necessary non-surgical sleep disorder device or components not under warranty will be considered **medically appropriate** when the following criteria are met:

A. Physician documentation includes **ALL** of the following:

1. date of device implantation/initiation;
2. manufacturer warranty information, if applicable;
3. attestation that the patient has been compliant with the use of device and will continue to benefit from the use of device;

B. The device is no longer functioning adequately; and **BOTH** of the following criteria are met:

1. inadequate function interferes with activities of daily living; **and**
2. repair is expected to make the equipment fully functional (as defined by manufacturer).

XV. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

Device Replacement

XVI. Replacement of a medically necessary non-surgical sleep disorder device or components not under warranty will be considered **medically appropriate** when **EITHER** of the following criteria are met:

A. The device is no longer functioning adequately and has been determined to be non-repairable, or the cost of the repair is in excess of the replacement cost;

B. There is documentation that a change in the patient's condition makes the present unit non-functional and improvement is expected with a replacement unit.

XVII. The replacement of a properly functioning non-surgical sleep disorder device, its components or accessories are considered **not medically necessary**. This includes, but is not limited to, replacement desired due to advanced technology or in order to make the device more

aesthetically pleasing;

XVIII. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

XIX. Accessories or components for non-surgical sleep disorder devices that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan.

RELATED POLICIES

Corporate Medical Policy

1.01.00 Durable Medical Equipment (DME) and Devices, Standard and Non-Standard

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)

CPAP

I. Individuals who do not meet the criteria for continuation of coverage during the initial 90 day trial are eligible to re-qualify for a CPAP device, but must have a clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to CPAP therapy (e.g., documentation of failure of symptoms to resolve or improper fit of device, and re-education of the individuals regarding proper use of the equipment or re-fitting of masks).

I. CPAP with expiratory relief or APAP are options for patients who cannot tolerate the high constant air pressure associated with CPAP but wish to continue treatment for OSA.

II. Supplemental oxygen or humidification can be added to positive pressure devices to increase oxygen saturation and decrease vasomotor rhinitis.

III. Coverage is allowed for a one-month rental when the CPAP device is malfunctioning and out of warranty, (and not associated with a manufacturer recall) while the device is being repaired.

IV. The monitoring feature/device, stand-alone or integrated, any type, including all accessories, components, and electronics, not otherwise classified (HCPCS: A9279) is considered inclusive to the positive airway pressure device.

V. Devices used to clean or sanitize CPAP devices are considered a convenience item and are ineligible for coverage (e.g., SoClean, SoClean 2 Go).

Oral Appliances

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.

Primary Snoring

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.

Sleep Apnea

Sleep apnea is a common sleep disorder characterized by repeated interruptions in breathing during sleep. These interruptions called apnea can occur hundreds of times per night which can lead to fragmented sleep and decreased oxygen levels resulting in daytime fatigue, cardiovascular problems, and other health issues.

Obstructive Sleep Apnea (OSA)

Obstructive sleep apnea (OSA) is a sleep-related breathing disorder (the most common type) caused by upper-airway obstruction, most often from relaxed throat muscles during sleep. In adults, OSA involves recurrent episodes of complete or partial upper airway blockage lasting more than 10 seconds and is commonly linked to obesity, male sex, aging, and anatomical factors. Symptoms include loud snoring, witnessed apneas, gasping, excessive daytime sleepiness, and hypertension, and diagnosis requires polysomnography or home sleep testing with evidence of clinical impairment. Untreated adult OSA increases the risk of hypertension, heart failure, atrial fibrillation, other arrhythmias, and nonalcoholic fatty liver disease.

Pediatric OSA, typically caused by enlarged tonsils and adenoids, is defined by prolonged partial obstruction or intermittent complete obstruction lasting at least two respiratory cycles and may present with snoring, breathing pauses, restless sleep, behavioral issues, or poor growth. If left untreated, children may experience growth abnormalities, neurologic problems, or cor pulmonale. Polysomnography (PSG) is the preferred diagnostic tool, although normative AHI/RDI values for

children are not well established. Adenotonsillectomy is first-line therapy for pediatric OSA, while persistent cases or those with contraindications may require CPAP, observation, medications, or additional airway surgery. Obstructive hypoventilation (OH), a related condition in children, may present with normal AHI but episodes of hypercarbia indicated by elevated end-tidal CO_2.

Central Apneas

Central sleep apnea is defined as the cessation of airflow through the nose and mouth for at least 10 seconds with no respiratory effort noted. 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. Approximately 4% of individuals undergoing PSG in a sleep laboratory are diagnosed with central sleep apnea, making this an uncommon condition.

Mixed Apneas

Mixed sleep apnea is a combination of obstructive and central sleep apnea. Not only does the patient have an obstruction in the airway, but the patient may have a neurological dysfunction or cardiopulmonary as well that contributes to the central apnea component.

Continuous Positive Airway Pressure (CPAP)

CPAP is the gold standard treatment option for adults with documented OSA. The symptoms associated with OSA, such as excessive daytime sleepiness, impaired cognition, and mood disorders are reduced or eliminated with the consistent use of CPAP. CPAP is not indicated in individuals with simple snoring that is not associated with pauses in respirations. Treatment recommendations for OSA are based primarily on the RDI or the AHI, the severity of the presenting symptoms, and the existence and severity of co-morbid conditions.

CPAP provides constant pressure throughout the respiratory cycle by raising the intraluminal upper airway pressure above the positive critical transmural pressure of the pharynx or hypopharynx. The pressure is delivered by a flow generator through either nasal mask or modified nasal prongs to keep the upper airway patent resulting in adequate ventilation and arterial oxygenation. The pressure used is determined individually, with a range of 3 to 20 cm. water.

Auto- or Self-Titrating Positive Airway Pressure (APAP)

Auto- or self-titrating positive airway pressure, or APAP, systems utilize an algorithm that uses a pressure transducer and microprocessor to monitor the airway for vibration patterns and then makes air pressure adjustments based on the incidence of apnea or absence of vibration. APAP devices are also referred to as demand positive airway pressure devices (DPAP).

CPAP with expiratory relief (e.g., C- Flex technology Respironics, Inc., Murrysville, PA) is designed to provide pressure relief during expiration, while maintaining optimal pneumatic splinting for effective therapy. CPAP with expiratory relief technology monitors the patient's airflow during expiration and reduces expiratory pressure proportional to expiratory flow. CPAP with C-Flex technology can increase compliance in those patients who find it difficult or uncomfortable to breathe out against the

continuous positive pressure. This technology can be applied to CPAP, BPAP and APAP devices.

Most PAP machines now contain a data card that can record and transmit daily use rates of the device. In addition, most PAP machines can also be equipped with a modem (either wired or wireless) that is capable of transmitting data daily to a manufacturer-owned database. The ability to detect disturbances in a variety of measures, including air flow, amount of time used, and mask leak, is also included in most commercially available PAP machines.

Upper Airway Resistance Syndrome (UARS)

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.

Hypoventilation Disorders

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.

Hypoxemia

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 or noodles or devices that can be placed on the body that vibrate or inflate when in the supine sleep.

SUPPORTIVE LITERATURE

CPAP

Figard et al (2025) conducted an umbrella review of meta-analysis of randomized controlled trials that evaluated the effectiveness, adherence, and safety of treatments for OSA by synthesizing evidence from 34 meta-analyses of 230 randomized controlled trials involving 36,353 participants. The review found that CPAP remains the most effective treatment for reducing the AHI and improving daytime sleepiness. Other interventions, including glucagon-like peptide-1 (GLP-1) receptor agonists such as tirzepatide and MADs, also significantly reduced OSA severity, although to a lesser extent than CPAP. Daytime sleepiness improved with CPAP, hypoglossal nerve stimulation (HNS), wake-promoting medications, and myofunctional therapy. Physical activity produced the greatest improvements in quality of life, while CPAP provided more modest benefits. Overall, most of the evidence was of low to moderate certainty, with only one meta-analysis providing high-certainty evidence. The authors concluded that CPAP remains the most effective therapy for OSA, but alternative treatments may offer meaningful benefits for selected patients. However, limited data on long-term adherence, safety, and combination therapies highlight the need for further comparative and long-term research to support individualized treatment approaches. The findings should also be interpreted cautiously because of limitations related to the quality of the included meta-analyses and their selection criteria.

Sanchez-de la-Torre et al (2023) conducted a systematic review and meta-analysis of individual participant data (IPD) from three RCT, Sleep Apnea Cardiovascular Endpoints (SAVE), Impact of Sleep Apnea Syndrome in Acute Coronary Syndrome (ISAACC) and Randomized Intervention with CPAP in Coronary Artery Disease and Sleep Apnea (RICCADSAO) to assess whether adherence to CPAP therapy reduces the risk of major adverse cardiac and cerebrovascular events (MACCEs) in

individuals with OSA and established cardiovascular disease. The study included 4186 adults with cardiovascular disease and OSA. The primary outcome was the first MACCEs. Statistical analysis included one stage and two stage IPD meta-analysis as well as on treatment analysis using marginal structural models to assess the effects of CPAP adherence. A total of 691 MACCEs (16.5%) were observed, the CPAP group had 349 and the no CPAP group 342. The main outcome intention- to-treat analysis did not show a significant difference in MACCEs between the CPAP and the no CPAP group. The on-treatment analysis revealed good adherence to CPAP (≥4 hours per day) was associated with a reduced risk of MAACEs reoccurrence. Adherence to CPAP was associated with reduced MACCE recurrent risks suggesting that treatment adherence is a key factor in secondary cardiovascular prevention in individuals with OSA.

Patil et al (2019) conducted a systematic review and meta-analysis of 184 studies to evaluate the effectiveness of PAP therapy for adults with OSA. CPAP significantly reduced AHI by 23 events/hour versus no treatment—an 86% reduction from 32.7 to 4.1 events/hour. CPAP also improved daytime sleepiness by 2.4 points in symptomatic patients and showed clinically meaningful benefits for sleep-related quality of life, blood pressure, and motor vehicle crash risk. Observational evidence suggested reductions in cardiovascular events and mortality, though RCTs did not confirm these outcomes. No major differences were found among CPAP, APAP, and BiPAP for individual clinical outcomes, supporting CPAP as first-line therapy unless not tolerated. Home-based versus in-lab APAP initiation showed comparable results. Education, behavioral interventions, and telemonitoring improved adherence. Nasal masks enhanced adherence and reduced AHI more effectively than oronasal masks. Humidification reduced side effects without improving adherence or outcomes. Overall, CPAP reliably reduces OSA severity, improves sleepiness, and lowers blood pressure, particularly in symptomatic or hypertensive adults. Benefits for asymptomatic individuals and long-term cardiovascular outcomes remain uncertain.

Wang et al (2019) conducted a systematic review to assess the effectiveness of home noninvasive NIPPV (home mechanical ventilation (HMV), BiPAP, or CPAP devices) in adults with chronic respiratory failure. 68 studies evaluating 53,733 patients were included. In patients with COPD, home BiPAP (compared to no device) was associated with lower mortality, decreased need for intubations and hospital admissions, but no change in quality of life. In patients with COPD, HMV (compared individually with BiPAP, CPAP, or no device) was associated with fewer hospital admissions. In patients with thoracic restrictive diseases, HMV (compared to no device) was associated with lower mortality. In patients with neuromuscular diseases, home BiPAP (compared to no device) was associated with lower mortality and better quality of life. In patients with obesity hypoventilation syndrome, home HMV/BiPAP (compared to no device) was associated with lower mortality. Current evidence was not available to assess the comparative effectiveness of many device capabilities on patient outcomes. Criteria to initiate home NIPPV and home respiratory services varied and were not validated in comparative studies.

Oral Appliances (OAs)

Gupta et al (2026) conducted a systematic review and meta-analysis evaluating the effectiveness of mandibular advancement devices (MADs) compared with continuous positive airway pressure (CPAP)

and sham/control interventions in adults with obstructive sleep apnea (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 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. OA significantly improves 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 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."

The 2015 clinical practice guidelines that was jointly issued by the American Academy of Sleep Medicine (AASM) and the American Academy of Dental Sleep Medicine (AADSM) (Ramar et al), aimed to update and replace previous recommendations for the use of oral appliance therapy for adults with OSA. 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 2012 American Academy of Pediatrics Clinical Guidelines (Marcus et al) for the Diagnosis and Management of Childhood Obstructive Sleep Apnea Syndrome (OSAS), focusing on uncomplicated

OSAS (OSAS associated with adenotonsillar hypertrophy and/or obesity in otherwise healthy children). The recommendations are as follows:

- "All children/adolescents should be screened for snoring."
- "Polysomnography should be performed in children/adolescents with snoring and symptoms/signs of OSAS; if polysomnography is not available, then alternative diagnostic tests or referral to a specialist for more extensive evaluation may be considered. "
- "Adenotonsillectomy is recommended as the first-line treatment of patients with adenotonsillar hypertrophy.
    - High-risk patients should be monitored as inpatients postoperatively.
    - Patients should be reevaluated postoperatively to determine whether further treatment is required. Objective testing should be performed in patients who are high risk or have persistent symptoms/signs of OSAS after therapy.
    - Continuous positive airway pressure is recommended as treatment if adenotonsillectomy is not performed or if OSAS persists postoperatively."
- "Weight loss is recommended in addition to other therapy in patients who are overweight or obese. "
- "Intranasal corticosteroids are an option for children with mild OSAS in whom adenotonsillectomy is contraindicated or for mild postoperative OSAS."

The 2019 AASM clinical practice guidelines for the Treatment of Adult OSA with PAP (Patil et al) state the following recommendations:

- "Clinicians use PAP, compared to no therapy, to treat OSA in adults with excessive sleepiness. (strong)"
- "Clinicians use PAP, compared to no therapy, to treat OSA in adults with impaired sleep-related quality of life. (conditional)"
- Clinicians use PAP, compared to no therapy, to treat OSA in adults with comorbid hypertension. (conditional)
- "PAP therapy be initiated using either APAP at home or in-laboratory PAP titration in adults with OSA and no significant comorbidities. (strong)"
- "Clinicians use either CPAP or APAP for ongoing treatment of OSA in adults. (strong)"
- "Clinicians use CPAP or APAP over BPAP in the routine treatment of OSA in adults. (conditional)"
- "Educational interventions be given with initiation of PAP therapy in adults with OSA. (strong)"
- "Suggest that behavioral and/or troubleshooting interventions be given during the initial period of PAP therapy in adults with OSA. (conditional)"

- "Clinicians use telemonitoring-guided interventions during the initial period of PAP therapy in adults with OSA. (conditional)"

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
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management

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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
A7027-A7039	Accessories/supplies, code range for positive pressure airway devices (code range)
A7044-A7046	Accessories/supplies, code range for positive pressure airway devices (code range)

Code	Description
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified
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
E0561	Humidifier, nonheated, used with positive airway pressure device
E0562	Humidifier, heated, used with positive airway pressure device
E0601	Continuous airway pressure (CPAP) device
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
E66.2	Morbid (severe) obesity with alveolar hypoventilation
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)
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)
I50.9	Heart failure, unspecified
J39.8	Other specified diseases of upper respiratory tract
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J95.2	Acute pulmonary insufficiency following nonthoracic surgery
J96.00-J96.02	Acute respiratory failure (code range)
J96.10-J96.12	Chronic respiratory failure (code range)
J96.20-J96.22	Acute and chronic respiratory failure (code range)
J96.90-J96.92	Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia (code range)
J98.4	Other disorders of lung
J98.8	Other specified respiratory disorders

REFERENCES

Alajmi M, et al. Impact of continuous positive airway pressure therapy on blood pressure in patients with obstructive sleep apnea hypopnea: a meta-analysis of randomized controlled trials. Lung 2007 Mar-Apr;185(2):67-72.

American Academy of Dental Sleep Medicine (AADSM) [Internet]. Dental sleep medicine standards for screening, treatment, and management of sleep-related breathing disorders in adults using oral appliance therapy. [updated 2022; accessed 2026 Jul 17]. Available from: https://www.aadsm.org/docs/jdsm.10.10.2022.sa1.pdf

American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) [Internet]. Position statement: Use of oral appliances for the treatment of obstructive sleep apnea (OSA). [revised 2019 Nov 11; accessed 2026 Jul 17]. Available from: https://www.entnet.org/resource/position-statement-use-of-oral-appliances-for-the-treatment-of-obstructive-sleep-apnea-osa/

American Academy of Pediatrics [Internet]. Clinical practice guideline: diagnosis and management of childhood obstructive sleep apnea syndrome. Pediatrics 2002;109(4):704-712. [accessed 2026 Feb 13]. Available from: https://publications.aap.org/pediatrics/article/130/3/576/30284/Diagnosis-and-Management-of-Childhood-Obstructive?autologincheck=redirected

American Academy of Sleep Medicine. Practice parameters for the use of auto-titrating continuous positive airway pressure devices for titrating pressures and treating adult patients with obstructive sleep apnea. Sleep 2002;25(2):143-147.

Baptista PM, et al. Daytime neuromuscular electrical therapy of tongue muscles in improving snoring in individuals with primary snoring and mild obstructive sleep apnea. J Clin Med. 2021 Apr 27;10(9):1883

Benjafield Adam V, et al. Estimation of the global prevalence and burden of obstructive sleep apnoea: a literature-based analysis. The Lancet Respiratory Medicine 2019 Aug;7(8): 687–698.

Beri A, et al. Appliances therapy in obstructive sleep apnoea: a systematic review and meta-analysis. Cureus. 2023 Nov 4;15(11):e48280.

Chang H-P, et al. Obstructive sleep apnea treatment in adults. The Kaohsiung Journal of Medical Sciences 2019 Sept: 7-12.

Cistulli P, et al. Short-term CPAP adherence in obstructive sleep apnea: a big data analysis using real world data. Sleep Medicine 2019 Jul;59:114-116.

Downey R, et al. Nasal continuous positive airway pressure use in children with obstructive sleep apnea younger than 2 years of age. Chest 2000 Jun;117(6):1608-1612.

Figard C, et al. Effect of sleep apnoea interventions on multiple health outcomes: an umbrella review of meta-analyses of randomised controlled trials. EClinicalMedicine. 2025 Oct 8;89:103529.

Gupta AK, et al. Comparative effectiveness of mandibular advancement devices and continuous

positive airway pressure in adults with obstructive sleep apnea: a systematic review and meta-analysis. Sleep Med. 2026 Oct;146:109083.

Hady KK, et al. Positive airway pressure therapy for pediatric obstructive sleep apnea. Children 2021 Nov;8(11):979.

Hamoda MM, et al. Continuous positive airway pressure and mandibular advancement splints: the CHOICE multicentre, open-label randomised clinical trial. Eur Respir J. 2025 Apr 3;65(4):2401100.

Ioerger P, et al. Mandibular advancement vs combined airway and positional therapy for snoring: a randomized clinical trial. JAMA Otolaryngol Head Neck Surg. 2024 Jul 1;150(7):572-579.

Jacobowitz O, et al; on behalf Governing Council of the World Sleep Society. Endorsement of "European Respiratory Society guideline on non-CPAP therapies for obstructive sleep apnoea" by World Sleep Society. Sleep Med. 2024 Jan;113:293-298.

Javaheri S, et al. Treatment of OSA and its impact on cardiovascular disease, Part 2: JACC state-of-the-art review. J Am Coll Cardiol. 2024 Sep 24;84(13):1224-1240.

Johal A, et al. The role of oral appliance therapy in obstructive sleep apnoea. Eur Respir Rev. 2023 Jun 21;32(168):220257.

Johnson K, Johnson D. In reference to positive airway pressure titration task force of the American Academy of Sleep Medicine. Clinical guidelines for the manual titration of positive airway pressure in patients with obstructive sleep apnea. Journal of Clinical Sleep Medicine 2008;4:157-171. J Clin Sleep Med. 2008 Dec 15;4(6):610.

Kotecha B, et al. A novel intraoral neuromuscular stimulation device for treating sleep-disordered breathing. Sleep Breath. 2021 Dec;25(4):2083-2090.Kushida CA, et al. Positive Airway Pressure Titration Task Force; American Academy of Sleep Medicine. Clinical guidelines for the manual titration of positive airway pressure in patients with obstructive sleep apnea. J Clin Sleep Med. 2008 Apr 15;4(2):157-71.

Macrea M, et al. Long-term noninvasive ventilation in chronic stable hypercapnic chronic obstructive pulmonary disease: an official American Thoracic Society clinical practice guideline. Am J Respir Crit Care Med 2020 Aug 15;202(4):e74-e87.

Marcus CL, et al. Diagnosis and management of childhood obstructive sleep apnea syndrome. Pediatrics. 2012 Sep;130(3):576-84.

National Institute for Health and Care Excellence [Internet]. Obstructive sleep apnea/hypopnea syndrome and obesity hypoventilation syndrome in over 16s. Published Aug 2021. [accessed 2026 Aug 06]. Available from: https://www.nice.org.uk/guidance/NG202

Ng JH and Yow M. Oral appliances in the management of obstructive sleep apnea. Sleep Med Clin. 2019;14(1):109-118.

Ou YH, et al. Mandibular advancement vs CPAP for blood pressure reduction in patients with obstructive sleep apnea. J Am Coll Cardiol. 2024 May 7;83(18):1760-1772.

Patil SP, et al. Treatment of adult obstructive sleep apnea with positive airway pressure: an American Academy of Sleep Medicine Clinical Practice Guideline. J Clin Sleep Med 2019 Feb 15;15(2):335-343.

Qaseem A, et al; Clinical Guidelines Committee of the American College of Physicians. Management of obstructive sleep apnea in adults: A clinical practice guideline from the American College of Physicians. Ann Intern Med. 2013 Oct 1;159(7):471-83.

Ramar K, et al. 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 Jul 15;11(7):773-827.

Rossi A, et al. Clinical evidence in the treatment of obstructive sleep apnoea with oral appliances: a systematic review. Int J Dent. 2021 May 8;2021:6676158.

Sánchez-de-la-Torre M, et al. Adherence to CPAP treatment and the risk of recurrent cardiovascular events: a meta-analysis. JAMA. 2023 Oct 3;330(13):1255-1265.

Strohl, Kingman. Obstructive sleep apnea. Merck Manual 2020 Sept.

Uniken Venema JAM, Doff MHJ, Joffe-Sokolova D et al., Long-term obstructive sleep apnea therapy: a 10-year follow-up of mandibular advancement device and continuous positive airway pressure: J Clin Sleep. Med 2020 March 15;16(3) 353-359.

Veasey SC, Rosen IM. Obstructive sleep apnea in adults. N Engl J Med. 2019 Apr 11;380(15):1442-1449.

Wang Z, et al. Noninvasive positive pressure ventilation in the home. Rockville (MD): Agency for Healthcare Research and Quality (US); 2019 Mar 14. PMID: 32101390.

Weiss MR, et al. Defining the patterns of pap adherence in pediatric obstructive sleep apnea: a clustering analysis using real world data. Journal of Clinical Sleep Medicine 2020 May;17 (5):1005-1013.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Durable Medical Equipment Reference List (NCD 280.1) [accessed 2026 Aug 06]

Oral Appliances for Obstructive Sleep Apnea (LCD L33611) [accessed 2026 Aug 06]

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (LCD L33718) [accessed 2026 Aug 06]

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	
10/22/26	
Date	**Summary of Changes**
02/15/27	• Original effective date
10/22/26	• New policy; Content merged from CMP #1.01.06 Continuous Positive Airway Pressure (CPAP) and Auto Adjusting Positive Airway Pressure (APAP) Devices and CMP #1.01.07 Medical Management of Obstructive Sleep Apnea. Policy intent unchanged.