INCORPORATING SLEEP APNEA APPLIANCES INTO YOUR DENTAL PRACTICE: FROM SCREENING YOUR PATIENTS TO BILLING INSURANCE

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OVERVIEW

• **Basic** Sleep Physiology
• Screening Dental Patients
• HST/Lab testing

• Appliances
• Appliance Complications
• Insurance
BASIC SLEEP PHYSIOLOGY

• Sleep is a complex series of events
• Balanced by neurotransmitters in the brain and brainstem
• Affected by light and daily natural rhythms
SLEEP DISORDERED BREATHING

- Patients are tired all the time
  - Key symptom: daytime sleepiness
- Patients are constantly awakened by pharyngeal collapse
- Prevalence and severity increase with age and weight
DEFINITIONS

• A sleep-related breathing disorder
  – A complete stop in airflow despite continuing efforts to breathe
    • Decrease in airflow is a HYPOPNEA
    • Stopping of airflow is an APNEA
      – This decrease or blockage needs to last 10 seconds or more during sleep-REM

• Measurement of Oxygen Saturation
DEFINITIONS

• **Upper Airway Resistance Syndrome (UARS)**- frequent arousals in response to increased respiratory effort as a result of upper airway narrowing, without overt apnea or hypopnea.

• **Apnea/Hypopnea Index (AHI)**- the number of these obstructive or partially obstructive events per hour (aka Respiratory Distress Index-RDI)- normal is considered less than 10

• **Oxygen Saturation-(SaO2)** The level of O₂ in the arterial blood (pulse oximetry)
WHO GETS OSAS?

• 12 million Americans have OSA
• Only about 2 million have been diagnosed
  – OSA with daytime sleepiness=OSA syndrome
    • 4% of men and 2% of women
  – OSA without daytime sleepiness
    • 24% of men and 9% of women
    • 38% of all hypertensive patients
    • 50% of obese men; 60-70% of diabetics
  – 2% of children: Ages 2-8 most commonly associated with large ???
HOW BIG A PROBLEM IS OSA?

• OSA May afflict up to 17% of Americans
  – 24% men; 9% women

• Patients with OSA are at a greater risk for hypertension, heart attack, stroke, diabetes and depression

• Patients with OSA are involved in traffic accidents 2-3 times more often than the general population

• Patient with OSA are at an increased risk for injury in the workplace
PREVALENCE

• OSA with or without daytime sleepiness
  – 24% of men and 9% of women
  – 38 % of hypertensive patients
  – 50% of Obese men (BMI Scale)

• 2% of children: Ages 2-8
  – Pre-maturity increase OSA 3-5x
  – Generally associated with Large ???
IDENTIFYING PATIENTS AT RISK

• Dentist is an important entry point for identification and treatment of OSA
  • Sleep and Breathing 2007

• Visits to the dentist in a 12 month period
  – 65% of Adults 18-65
  – 58% of Adults > 65
  • JADA Jan 2010

• Not going to their medical providers

• Similar to hypertension in the 70’s and 80’s
AN INVISIBLE PATIENT POPULATION

Percentage of sleep disorder patients who actively seek treatment

- 68% never discussed
- 26% secondary reason
- 2% primary reason
OSA UNDER-DIAGNOSED
HOW IS IT MEASURED?

• NON-CLINICAL
  – QUESTIONNAIRES

• CLINICAL

• SLEEP TESTING
  – HST
  – OVERNIGHT IN-LAB
    – PSG
SLEEP STUDY REPORT

• Report of findings from the sleep study
  – AHI
  – RDI
  – PERIODIC LIMB MOVEMENTS
    • RESTLEG LEG
  – OXYGEN SATURATION
AHI

- MILD
- MODERATE
- SEVERE
RECOGNIZING SLEEP APNEA PATIENTS IN YOUR OFFICE

• SCREEN EXISTING AND NEW PATIENTS
  – APPROPRIATE QUESTIONS ON HEALTH HISTORY
  – MEDICATION LIST
  – ASK ABOUT CPAP/OSA

• ROUTINE DENTAL EXAM TO LOOK FOR ORAL RISK FACTORS FOR SNORING AND OSA
INITIAL ENTRY POINT-SCREEN THE HEALTH HISTORY

- CONDITIONS/DISEASES
- MEDICATIONS
  - MEDICATIONS FOR CONDITIONS/DISEASES
  - MEDICATIONS FOR WAKEFULNESS
- QUESTIONNAIRES
  - STOP-BANG/BERLIN/EPWORTH
SCREEN FOR COMORBID DISEASES AND CONDITIONS-HEALTH HISTORY

- HBP-CARDIOVASCULAR DISEASE
- DIABETES
- GERD
  - PREVACID/PRILLOSEC
- DEPRESSION
  - SSRI’s
HEALTH HISTORY-SCREENING QUESTIONNAIRES

• EPWORTH
• BERLIN (BMI)
• STOP/BANG
Screening for Sleep Apnea
the following questions should guide clinical suspicion

• Snoring
  – Do you snore most nights (more than 3x/week)?
  – Is your snoring loud (heard through a wall or door)?
    • Yes ; No

• Has it ever been reported to you that you stop breathing or gasp during sleep?
  • Yes ; No
  • Never ; Occasionally ; Frequently
Screening for Sleep Apnea
the following questions should guide
clinical suspicion

• What is your collar size?
  • Male: 17”
  • Female: 16”

• Have you had, or are you currently being treated for
  high blood pressure?
  • Yes; No

• Do you occasionally doze or fall asleep during the day when:
  – You are not busy or active? Yes; No
  – You are driving or stopped at a light? Yes; No
SCREEN FOR BRUXISM/PARAFUNCTION

• ASSOCIATION WITH OSA
• RMMD

IDENTIFYING BRUXISM/PARAFUNCTION CAN BE AN ENTRY POINT FOR DENTISTS
RED FLAGS FOR BRUXISM

• MEDICAL CONDITIONS
• MEDICATIONS that may precipitate bruxism
• Bruxism related to Habits
BRUXISM RELATED TO MEDICAL CONDITIONS

• CEREBRAL PALSY
• TORTICOLLIS
MEDICATIONS THAT MAY PRECIPITATE BRUXISM

• SSRI’S
• AMPHETAMINES-RITALIN
• PROVIGIL-USED IN OSA PROMOTES WAKEFULNESS
• ADDERALL
BRUXISM RELATED TO:

- ALCOHOL
- CAFFEINE
- NICOTENE
- STREET DRUGS - METH/COCAINE/ECTASY
RISK FACTORS FOR BRUXISM
(IN THE ORDER OF RISK)

• Obstructive Sleep apnea
• Loud Snoring
• Snoring but less loud
• Moderate daytime sleepiness
• Alcohol use (<2 drinks/day)

• Heavy alcohol use (>3 drinks/day)
• Caffeine
• Smoker
• High stress
• Anxiety

Ohanon M, Li K: Chest 2001
Lavigne, G: Bruxism
EXAM

• Soft tissue/oral cancer exam
• Dental Exam-Pre-Appliance
  – Need at least 10 teeth per arch
  – No decay
  – All dental work needs to be completed
• Dental Occlusal Relationships
  – OJ/OB; Angles Classification; midlines; wear facets; occlusal contacts; diastema’s
• Periodontal Exam
• Study Casts (Diagnostic Models)

• Dental x-rays
• Panorex x-ray
• Cephalometric x-ray
• I-Cat Imaging-Other 3D
• MRI
DENTAL EXAM

- WEAR ON TEETH
- TORI
- SIZE OF TONGUE
- TONGUE SCALLOPING
- NARROW/HIGH HARD PALATE
- LONG SOFT PALATE-(MALLAMPATI I-IV)
- LONG UVULA
- TONSILS (GRADE 0-4)
- SHOULD BE ABLE TO SEE THE BACK OF THE THROAT
Examination Observations

Mandibular tori

Deviated septum
TONSILLAR CLASSIFICATION

- Grade 1+ Tonsil
- Grade 2+ Tonsil
- Grade 3+ Tonsil
- Grade 4+ Tonsil

<25% <75% <50% >75%
MALLAMPATI
RADIOGRAPHIC EXAM

- CEPHALOMETRICS
- 3DCT IMAGING
  - DOLPHIN
  - ANATOMOMAGE
Total Volume: 6.3cc
Min Area: 60.0mm²
POSSIBILITY OF OSA BASED ON AIRWAY DIMENSIONS

- HIGH <52MM$^2$
- INTERMEDIATE 52MM-110MM$^2$
- LOW >110MM$^2$

Hatcher D. Cone Beam Computed Tomography: Craniofacial and Airway Analysis. Sleep Med Clin (December 2009).
Sleep Study/Outcome

- AHI 1.9/REM 8.4
- RDI 4.1
- $O_2$ 95%
- Position
  - Supine 10 minutes of study  AHI 48
  - Side AHI 1.5
DIAGNOSIS

• Always done with a sleep study
  — Polysomnogram (PSG)
    • Attended in a Lab
    • Unattended at home
  — Diagnosis must ALWAYS be done by a Physician based on the sleep study
    • Normal sleep environment
    • “Worst case Scenario”
"Your lectures cured my sleep disorder,"
OVERVIEW OF APPLIANCES
WHEN TO CONSIDER AN ORAL APPLIANCE?

- After behavioral measures have begun
  - Weight reduction
  - Positional sleep changes
  - Discontinuation of alcohol
  - Medication management

  AND

- Patients who cannot tolerate CPAP
- Patients who travel frequently
- Patients who are not willing to consider a surgical procedure
- Patients who have had a surgical procedure and failed
- Patients who want to consider an appliance in combination with CPAP to avoid a surgical procedure
Indications for an Oral Appliance

- CPAP INTOLERANCE / NON-COMPLIANCE
- TRAVELING/CAMPING
- COMBINATION THERAPY-MADE TO USE WITH CPAP
CONTRA-INDICATIONS

• Central Sleep Apnea
• TMD
• Lack of sufficient teeth
• Un-motivated patient
TYPES OF ORAL APPLIANCES FOR OSA

- Tongue retaining device (TRD)
  - Denture patients
  - Gaggers
  - Patients with a limited number of teeth
- Non-adjustable appliances
- Adjustable appliances
  - Different materials
  - Types
- All do the same thing - open the airway and keep it open
POTENTIAL ADVERSE SIDE EFFECTS

• PERMANENT CHANGES IN OCCLUSION
• DRY MOUTH/EXCESSIVE SALIVATION
• SOFT TISSUE IRRITATION
• TEMPORARY BITE CHANGES
• TOOTH DISCOMFORT/TMD DISCOMFORT
• OPENING OF CONTACTS
• BEGINNING OF TM JOINT NOISES
TONGUE RETAINERS

• EASY
• SIMPLE
• INEXPENSIVE
• AVEO
• GREAT LAKES
  — OVER-THE-COUNTER
  — CUSTOM MADE
ALPHABETICAL LISTING OF APPLIANCES

• Thermoplastic
• 2 piece/1 piece
• OTC/Lab
Adjustable PM Positioner/APM Ultra

- Parker Mandibular Positioner
- Fixed/Adjustable
- Design permits lateral movements
- No metal clasps
- Thermoplastic
- APM Ultra-smaller size
APNEA Rx

- Titratable “transition” appliance
- Sold by Care Fusion

Key Features:

**Comfort-Fit™**
Within minutes, ApneaRx is thermally molded to the patient’s mouth for a 'same day' custom fit.

**Advanced Design**
ApneaRx does not use any screws, springs, rods, rubber bands, or torsion to adjust or maintain jaw advancement.

**Micro-Fit™**
Easy to read 1mm increment jaw advancement delivers maximum clinical efficacy.

**V-Flow™**
Assures full airflow and device alignment for stability and better fit.

**Posi-Lock™**
Jaw advancement mechanism can be set and relocked at any time.

**T-Control™**
Optional and modular tongue control and positioning system for those patients needing it.
DEPROGRAMMER

• USE IN AM TO DECREASE THE OCCLUSAL EFFECTS OR ELIMINATE THE EFFECTS OF OSA APPLIANCE
ELASTOMERIC APPLIANCE

• ONE PIECE APPLIANCE
• MINIMUM 5MM VERTICAL OPENING
• SOFT MATERIAL-VERY COMFORTABLE
• NON-ADJUSTABLE
EMA-ELASTIC MANDIBULAR ADVANCEMENT

- MAXIMUM PROTRUSIVE-LIMITED BY THE LENGTH OF THE STRAPS
- 2 PIECE APPLIANCE
- MINIMAL BULK
- ELASTIC STRAPS CAN BE EXPENSIVE
- ELASTICS ARE LATEX
FULL BREATH SOLUTIONS

- Depresses Posterior Tongue—therefore holds the tongue forward
- Single Arch—1 piece appliance
- Smaller design (size)
- Designed for mandibular arch
DORSAL

• Similar to other popular appliances
• Made by Space Maintainers/Dynaflex
• 2 Piece appliance
DNA

- Daytime/Nighttime Appliance
- “epigenetic orthodontics”
- Works by altering “DNA” strands?
- Arch widening appliance
- Science behind this appliance?
HERBST

• 2 piece appliance
• Maximum protrusive-5mm with telescopic bars/unlimited with shims
• Has Heavier Set of Bars for “Big” Patients and bruxers
• Make a soft Herbst
HILSEN ADJUSTABLE POSITIONING APPLIANCE

• Velcro-like attachments cover surfaces of the teeth
KLEARWAY

- 1 piece appliance-Engages upper and lower arches simultaneously
- Uses a single screw in palate for adjustments
- Thermoplastic
- Great Lakes Ortho-Lab
LAMBERT SLEEP WELL

- Simple 2 piece design
MANDIBULAR INCLINED REPOSITIONING SPLINT (MIRS)

- APPEARS SIMILAR TO A REPOSITIONING SPLINT-GREAT LAKES
- 1 PIECE APPLIANCE
- THERMOPLASTIC
MONOBLOCK

• Original OSA Appliance-research done with this appliance
The Moses

- 1 piece appliance
- Appliance Does Not cover all the incisal surfaces of the teeth
Narval

- Resmed Narval™
- CAD/CAM Device
- “Metal Free/Flexible/Light”
- Great Lakes
Nocturnal Airway Patency Appliance (NAPA)

- Breathing beak - Allows for oral breathing when necessary
- Need 5-10mm of vertical opening
Nose Breathe Appliance [NB]

• Designed to decrease the activity of the tongue
• For Heavy Snorers NB/HS
NORAD

- Nocturnal ORal Airway Dilator
- Auto-titratable
- Bulky
- Heat/trim-in office
- “Works well for big person”
- Inexpensive
OASYS

• Dual Purpose Appliance
  – Oral pharyngeal
  – Nasal dilator

• Fragile
O2 OASYS

• 2\textsuperscript{ND} GENERATION
Over the Counter Snoring Appliances

- Ripsnore
- Pure Sleep
- Snoremate
- Snoremender
- SnoreRx
ProSnore

- OTC Kit
- Patient takes their own impression
- Patient sends it to special lab
- Get back titratable appliance
Respire

- Blue
- Pink
RESPIRE GREEN
SILENCER

- SILENCER PROFESSIONAL IS LAB FABRICATED
- EASY FOR PATIENTS TO ADJUST
- “SYSTEM”
- NO POSTERIOR SUPPORT
- EASY FOR PATIENTS TO ADJUST
SOMNOMED MAS

• COMMON APPLIANCE
• USEFUL FOR MOST SITUATIONS
SOMNODENT G2

- INCREASE VERTICAL HEIGHT
- ADVANCE PROTRUSION
SILENT NIGHT-SLIDE-LINK

“Titratable/Temporary Appliance”
• Glidewell
• No posterior occlusion
• Uses plastic devices to protrude mandible
• Low Cost
• Simple to adjust
• 5mm total protrusive adjustment from start position
SUAD ELITE/ULTRA/TSA

- BIG/BULKY
- EXTREMELY RIGID
- HERBST BARS
- ULTRA-MORE RIGID THAN ELITE
- TSA-TEMPORARY SUAD APPLIANCE
SUE/SUE 2G

- SUAD ULTRA ELITE (SUE)
- 2G IS “SECOND GENERATION"
- COMBINES METAL ANTERIORS WITH ACRYLIC BLOCKS AND HERBST ARCH BARS
- $$$
TAP I/TAP III Elite

- Thorton Adjustable Positioner
- TAP I-Classical Appliance
- TAP III-Adjustable in both vertical and horizontal plane
- TAP III-Elite allows more lateral movement
- 2 piece appliance
TAP-PAP

• Combination Appliance
  – Tap appliance
  – Standard CPAP technology
Sleep Apnea Airway Management System (SAAMS)

- Combination-
  - TAP Appliance
  - Standard CPAP technology
CPAP Pro

• Made to work with CPAP machine
• Nasal Pillow Device
• Attaches Either:
  – Boil and Bite
  – Standard Appliance
TheraSnore

- TheraSnore I-Original
- TheraSnore II-Adjustable
- One Piece
- Boil and bite appliance
- “for Bruxers”
Tongue Retaining Device

- KD Night Appliances
  - Racine, WI
  - Only made by one person
  - (262) 638-8343

- Measure Tongue
  - 3 Sizes

- Combination TRD and Splint device
• SIMPLE-SINGLE ARCH DESIGN
• LINGUAL APRON
Z APPLIANCE

- 2 PIECE COMBINATION APPLIANCE
- STANDARD HERBST BARS
- SOFT PALATE LIFTER
Z QUIET

- OTC APPLIANCE
- PATIENTS CAN BUY ON TV
- AGGRESSIVE PROTRUSIVE POSITION
TAKING THE BITE
PRE-BITE REGISTRATION

• Review diagnosis
• Review appliance types
• Have patient bite down on a cotton roll
• Use hand mirror to show them the exact position
• Leave them for about 5 minutes
• Write up your exam findings
GEORGE GAUGE

“For quick and accurate construction Bites”
• CUT OFF HANDLE OF GEORGE GAUGE
• TRY BITE IN
• CHECK LIP SEAL
POSSIBLE PROBLEMS

- HISTORY OF TMD PROBLEMS
- CLASS II/DIV I OR II
- EXTREMELY CROWDED CASES
- HIGH MANDIBULAR PLANE ANGLE
- GAG REFLEX
- LIMITED ROM
- SEVERE SLEEP APNEA
- CENTRAL SLEEP APNEA
- ADVANCED HEALTH PROBLEMS
- ELDERLY PATIENTS
• Appliances last about 5 years
• There are times when OSA appliances don’t work
• Patient may need OSA appliance and continue to use CPAP
• Patients don’t mind the side effects
• They justify the side effects by the results
• Soft results are based on daytime sleepiness
• Hard results based upon follow-up PSM
What is an Optimal Result?

- **Improved symptoms**
  - **Subjective**
    - Improvement of #’s screening questionnaire
    - Improved sleep
  - **Objective**
    - RDI (AHI) below 10
    - Oxygen desaturation levels at 90% or above
    - Reduction in the number of arousals
      - Arousal: an abrupt change in sleep state to a lighter state or to awake state
APPLIANCE COMPLICATIONS
DROOLING

• Common side-effect
• Usually short-lived
• Treatment:
  – Place a towel over pillow at night
  – Diphenhydramine before bed
VIVID

• Common side effect
• Theoretically patient is sleeping better
• Deeper sleep
• Treatment: Re-assure patient
Appliance Feels Too Tight

• If a 2 piece appliance try each piece on separately
• Reduce the pull on the clasping
• Reduce the acrylic on the inside of the appliance using a slow speed bur
SORE CHEEKS

• Possible Reasons
  – Can occur due to dry mouth
  – Bruxism
  – Sharp areas on appliance
  – Bulkiness of the appliance

• Treatment:
  – Check current medications-add oral moisturizer
  – Adjust and polish appliance
  – Cover irritating parts with wax until the patient gets used to the appliance-similar to patients in ortho
TMD PAIN

• Determine if muscle pain/joint pain or both

• INITIAL TREATMENT:
  – Check occlusion and alignment of the appliance
  – Even occlusion around the arch with the appliance in place
  – Midlines need to match pre-appliance midlines
TMD TREATMENT

• Determine if muscle pain/joint pain or both.
• Choices for treatment include any or all of the following:
  – DQ appliance or Reverse advancements
    • Ice/heat/soft diet
    • Night-time Muscle relaxants/NSAIDS
    • Physical Therapy
    • Botox
DIFFICULTY SWALLOWING

• TREATMENT:
  – Check appliance for size inside of mouth
    • Excessive vertical
    • Excessive initial protrusion
  – When placing appliance for the first time, make sure patient is comfortable
• Tinnitus can be concomitant with another problem “accidental tourist”

• TREATMENT:
  – Discontinue use to allow tinnitus to subside
  – Reverse recent advancements
  – Re-assume patient
TONGUE PAIN

• May be due to sharp edges of appliance
  – Smooth and polish appliance
• May be due to RMMA and tongue is getting bitten in the process
  – Change or tighten elastics
  – Consider changing the appliance design
  – Consider Material Allergy
MATERIAL

- Rare
- Resolve other problems
- Can become evident at any time during OAT therapy
  - Consider changing appliance
  - Can do allergy testing
GAGGING

• Need to check **before** making appliance

• **TREATMENT:**
  
  – Make the appliance smaller
    • Check for impingement on tongue space/palate
  
  – Have the patient use small amount of OTC benzocaine before placement
  
  – Start slow using appliance for a short time at first gradually increasing amount of use
OCCLUSAL CHANGES

- INFORMED CONSENT
- Common
- Can occur at any time
  - Initially
  - Treatment duration
- Patient has to try to return to normal occlusion during the day
  - Put patient on daytime re-alignment exercises
  - Treat as soon as possible
- Side effect of open posterior occlusion is usually not as great of a concern to the patient if they are sleeping better and feel rested during the day
Changes in Occlusion


• Bondemark L. Does 2 years nocturnal treatment with a mandibular advancement splint in adult patients with snoring and OSAS cause a change in the posture of the mandible? Am J Orthod Dentofacial Orthop. 1999;116:621-8


CHANGES IN OCCLUSION
GROWTH

• Late mandibular growth in late teens early 20’s
• Patient becomes a Class III or Mild Class III
• Recommend not managing with OG Surgery or Orthodontics unless patient insists. Growth may have occurred because of airway.
Changes in Occlusion

- Changes in occlusion are possible.
- Patients do not seem to be upset if their occlusion is slightly different.
- These devices violate the principles of occlusion.
- This rationale is based on the goal of this therapy and the risk vs. benefit ratio.
Minimize The Changes In Occlusion

- AM exercises
- Recognize changes ASAP
- Make changes in appliance design
  - Decrease the amount of vertical opening
  - Decrease the amount of mandibular protrusion
  - Decrease the time of appliance use
- Reasons for changes in occlusion:
  - Compression/rehydration of the disc tissue
  - Mandibular growth
  - Changes in the disc position
  - Others
OPEN CONTACTS

• Check contacts at your initial exam and chart accordingly

• Can occur at any time during treatment
  • Sometimes they were present before treatment and patient only notices them after onset of treatment

• TREATMENT:
  – Check appliance to see if forces are causing teeth to shift
  – Check for any teeth not embedded in acrylic to allow micro movements
  – Can have patient wear retainer to close contacts during the day for awhile
APPLIANCE ODORS

• Check for proper cleaning
• Brush the appliance in AM
• Can use products from dental lab/supply houses for cleaning
• Don’t let appliances soak during the day
• Leave appliance box open during day to let appliance dry out
• Can use Peridex 1-2x per week
RESIDUAL SLEEPINESS

- Patient may have other issues that need to be identified and addressed
  - Restless leg
  - Insomnia
  - Depression
  - Chronic pain
- Weight gain
- Re-check appliance for effectiveness
- Have them discuss with their PCP/sleep doctor
Increase in AHI/RDI During Follow-up PSG

- Not titrated properly
- May not be a mandible/tongue issue
- May have other problems related to anatomical problems
- May have a different sleeping position
- Cold/Allergy
EXPECTATIONS

• Unlikely/unrealistic expectations

• TREATMENT:
  – Patient education
  – Consider going back on CPAP for awhile
  – Consider using CPAP and the appliance for awhile-Dual therapy
TMD Splint Placement vs. OSA Appliance Placement

- Not substantially different
- Check Lip Seal
- An appliance on each arch
  - If appliance rocks or won’t seat all the way
  - Can try each appliance on separately
- Clean the same
- Patient Education
FOLLOW-UP

- 2 weeks/advance mandible
  - 4-6 weeks
- 2-3 months/Follow-up study
- Customize appliance follow-ups
INSURANCE
From the First Phone Call

• Phone Call Form
• Someone who knows insurance in your area
  – Geographic areas differ
Research Benefits

• Hire a medical billing service?
• Patient/Office staff
  – Questions to ask
  – Deductibles?
  – In network/out of network
  – Out of network
• HSA
Exam

• Include blood pressure
• Record face to face time in your chart notes
• Chart must include
  – cc; Hx; Exam; Diagnosis; Treatment plan; any additional comments.
• Need some sort of imaging/Panoramic/3DCT/ceph
Diagnosis

• Primary Codes
  – Obstructive Sleep Apnea (327.23)
  – Sleep Apnea with Hypersomnia (780.5)

• Secondary Codes
  – Hypertension
  – Diabetes
Add to chart notes

• Duration of today’s appointment was . . . . minutes

• Medical Decision Making, phone calls, treatment planning and report writing took an additional . . . minutes
Red Flags to Insurance Companies

- Referral source? Where did the patient come from?
- Dental Chart notations (prophy/exam)
- Diagnosis of TMD/OSA
- No sleep study
- Lack of Details
  - Lack of charting
  - Lack of diagnosis
  - Lack of treatment plan
Diagnosis

- Diagnosis Codes from ICD-10
- From Polysomnogram (PSG)
Diagnosis

• Primary Codes
  – OSA 327.23
  – OSA with Hypersomnia (780.51)

• Secondary Codes
  – Hypertension (401.9)
  – Diabetes (250.0)
  – Heart Failure Unspecified (428.9)
Pre-authorization

- After the exam the patient may request pre-authorization
- Send in form exactly as if billing without the dates of service
• Justification
• Minimize losses
  – Implants
  – Full Mouth Reconstruction
  – TMD
  – Invisalign
  – Snoring

• Ducks in a row
Ducks in a Row

- Referral from Sleep Physician or PCP
- Copy of Sleep Study
- CPAP Failure
- Epworth/Berlin/Stop-Bang
Report of Findings

• Narrative Report
  – INSURANCE
  – Referring DOCTOR
  – DENTIST
Additions to Your Reports

• History of sleep studies
• Subjective testing-Epworth/Stop-Bang/Berlin
• Intolerance to CPAP
• Comorbid conditions
  – Hypertension
  – Diabetes
  – GERD
• “Stop Breathing at night”
Insurance Billing

• Use the standard CMS 1500 form
• Most important part is . . . . .
  – Exam/Consultation
  – Charting
  – Notes
  – Treatment
  – Insurance billing

. . . . . . . . . . . . . . . . . . . All Match!
Treatment Codes

- CPT/CDT
- Defines how medical offices bill services
- Exam/re-exam/appliance/follow-up testing
- 99204/99213/E0486/95806
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Billing Codes for Exam/X-ray

- Panoramic 70330
- Evaluation/management
  - 99205/99204 Initial exam
  - 99212/99213 Follow-up exam
  - 99245/99244 Consultation
- Do not bill dental insurance under any circumstances
Durable Medical Equipment

• Supplier of Medical Equipment
  – Appliances require FDA approval
• Uses a different set of codes-HCPCS
  – Level II-Specific DME codes
• Medicare provider
  – opt out-every 2 years

• Provider of medical equipment
  – Medicare Part A-Hospitalization
  – Part B-everything else
  – Medicare won’t pay a dentist
• Medicare is the HMO standard
• Most companies use Medicare guidelines for treatment necessity
• Insurance companies want you to take Medicare fees
• Insurance companies may fax you expedited payment requests based on Medicare fees
Guidelines

• Patient has to have a face to face evaluation
• Testing has specific requirements
  – AHI or RDI greater than 15
  – AHI OR RDI 5-14 with comorbid conditions
  – AHI or RDI greater than 30 and patient cannot tolerate CPAP determined by physician
• Device is ordered by physician
• Provided by a licensed dentist-DME
“Remember: medical insurance is like a hospital gown—You’re never covered as much as you think you are”

- Documentation
- Properly filled out CMS 1500
- Narrative Report
- Copy of charting (if asked)
- Copy of Sleep Study (if asked)
- Prescription from Sleep Physician/PCP
- Intolerance to CPAP/Affidavit
INTRO/ADVANCED OSA

FRIDAY, AUGUST 22, 2014
• INTRODUCTION TO SLEEP MEDICINE-DAVID CLAMAN, M.D.
• APPLIANCES-CHRIS LAJOIE
• INSOMNIA-DENNIS BAILEY, D.D.S.

SATURDAY, AUGUST 23, 2014
• DENNIS BAILEY, D.D.S.
• GWYNE SMITH, M.D.
• STACEY QUO, D.D.S., M.D.
THE END

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