Patient Calls to Schedule an Appointment

Important questions to ask the patient:

1) Did the patient have a polysomnogram (PSG) done?
   - If yes, your office needs to obtain a copy prior to first appointment
   - If no, that's fine, your doctor can refer for a PSG at first appointment

2) What type of insurance does the patient have?
   - Make sure to obtain ID# and group # (you will need this info later!)

3) Obtain all other demographic information that is required by your office

PSG = polysomnogram; a sleep study performed in a sleep lab with a sleep technologist attending, recording data about sleep in real-time
BEFORE THE APPOINTMENT:
• Call the patient’s insurance company to verify benefit coverage for oral appliance and office visits (provide contracted CPT codes and diagnosis code)
• Make sure to obtain a phone # and/or fax # for the prior authorization department

BEFORE THE APPOINTMENT:
If the insurance company tells you that the oral appliance does NOT require prior-authorization still ask for:
  1) phone &
  2) fax number

YOU WILL ALWAYS WANT TO GET THIS SERVICE PRIOR-AUTHORIZED

INSURANCE 101: BOTH DIAGNOSIS & TREATMENT CODES
2 Types of codes used for medical insurance
1. **DIAGNOSIS** or ICD-10 codes
   (International Classification of Diseases)
2. **TREATMENT** or CPT codes
   (Current Procedural Terminology)
INSURANCE 101: CODING BOOKS

Coding book “bundles” can be obtained from the American Academy of Professional Coders (AAPC) website

www.aapc.com/medical-coding-books/bundles

AAPC CODING BOOK BUNDLES AVAILABLE

www.aapc.com/medical-coding-books/bundles

FIRST IMPRESSIONS ARE LASTING IMPRESSIONS

- PLAN
- PREPARE
- PERFORM
THE FIRST VISIT

Have patient complete the following:

1. Medical questionnaire
2. Make sure your office has copy of PSG/HST or patient has with at this appointment
3. Affidavit of CPAP intolerance (ACI)
   a. This form is only applicable to those patients who have previously tried CPAP
   b. Affidavit supports that patient has tried CPAP and/or 2) is intolerant (if applicable)
   c. Has mild-moderate OSA and chose MAD instead of CPAP

THE FIRST VISIT

• Affidavit of CPAP intolerance examples:
  • Mask leaks
  • Uncomfortable/claustrophobic
  • Discomfort caused by head gear/straps
  • An inability to get the mask to fit properly
  • Disturbed or interrupted sleep caused by the presence of the device
  • Latex allergy
  • An unconscious need to remove the CPAP apparatus at night

OBTAINING A REFERRAL FOR TREATMENT FROM THE PCP OR SPECIALIST

• A medical referral is necessary:
  a) necessary for treating
  b) necessary for reimbursement
• A medical referral can be:
  a) written on a prescription pad
  b) requested by the Dental Office and sent to the PCP or specialist
WHAT WE DO AT OUR OFFICE: THE SLEEP SCREENING VISIT

• Our office offers patients who have expressed an interest in having a potential SRBD problem diagnosed & treated, a free assessment called a Sleep Screening (SS).

• The SS visit is a fact-gathering visit to:
  1) determine if the patient has physical risk factors for Obstructive Sleep Apnea (OSA) and
  2) has diseases for which are known as Co-Morbid. Conditions often associated with undiagnosed or untreated OSA.

• If the patient has had a PSG done, the doctor will review the results to determine if oral appliance therapy would be appropriate treatment.

• If the patient has NOT already had a PSG, the doctor will refer the patient to sleep lab/clinic/hospital for PSG to be completed.

In some instances, the patient will not be given the option of a PSG, but will provided with a one night Home Sleep Test (HST).

*COMORBIDITY: is the presence of one or more additional diseases or disorders co-occurring and oftentimes develop from a primary disease or disorder.
THE NEXT STEP

• So, the patient snores and complains of being tired all of the time
• Your patient has been told that he or she "stops breathing during the night" so obviously the patient has obstructive sleep apnea, correct?
  o NO, not necessarily; probability is about 70%
• So, we are now ready to apply for prior authorization with their health insurance, right?
  o NO!

OBJECTIVE TESTING HAS TO SHOW THAT PATIENT HAS OBSTRUCTIVE SLEEP APNEA WHICH MEANS A SLEEP STUDY

Has your patient had a PSG?

• Obtain a copy of the sleep study
• Schedule next follow-up (2-3 weeks out)
• Obtain prior authorization

PATIENTS HAS BEEN REFERRED FOR PSG: KEEP IN TOUCH!

• After sleep screening, if patient has been referred for PSG, make sure to:
  1. Call them to find out if PSG performed (if sleep lab/clinic/hospital did not send you results)
  2. If yes, schedule next follow-up appointment
     a. Obtain results of PSG
     b. Start prior-authorization
  3. If no, continue to follow-up with them
PREPARING A PRIOR-AUTHORIZATION: FORMS NEEDED
1. Affidavit for non-tolerance of CPAP (if applicable)
2. Sleep study
3. Medical questionnaire from patient
4. Consult notes from pulmonologist that saw patient pre PSG and order form from pulmonologist or referring doctor (Insurance dependent)
5. The more documentation to support necessity of treatment the better!

PREPARING A PRIOR-AUTHORIZATION: ELIGIBILITY

<table>
<thead>
<tr>
<th>AHI for diagnosis and classification of OSA</th>
<th>Events per hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mild OSA</td>
<td>5-15</td>
</tr>
<tr>
<td>Moderate OSA</td>
<td>15-30</td>
</tr>
<tr>
<td>Severe OSA</td>
<td>&gt;30</td>
</tr>
</tbody>
</table>

AHI = apnea-hypopnea index, OSA = Obstructive Sleep Apnea

1. Mild OSA
   - AHI ≤ 5

2. Moderate OSA
   - AHI > 5 and ≤ 15
   - RDI ≤ 15 and ≥ 20 events/h AHI
   - at least one of the following:
     - The patient is not a candidate for positive airflow pressure therapy or positive airway pressure therapy or airway pressure or airway pressure compliance program or
     - Positive airway pressure therapy has not been effective despite a 45 day trial period and participation in a positive airway pressure compliance program or
     - The patient has tried CPAP but has not been compliant despite a 45 day trial period and participation in a positive airway pressure compliance program or
     - The patient prefers to use an Oral Appliance rather than PAP as the initial therapy

3. Severe OSA
   - AHI > 15
   - RDI > 15
   - at least one of the following:
     - The patient is not a candidate for positive airflow pressure therapy or positive airway pressure therapy or airway pressure or airway pressure compliance program or
     - Positive airway pressure therapy has not been effective despite a 45 day trial period and participation in a positive airway pressure compliance program or
     - The patient has tried CPAP but has not been compliant despite a 45 day trial period and participation in a positive airway pressure compliance program or
     - The patient prefers to use an Oral Appliance rather than PAP as the initial therapy
PREPARING A PRIOR-AUTHORIZATION

- You can submit authorization:
  - Via phone
  - Via web portal

United Healthcare: https://www.uhcprovider.com
UMR: https://www.umr.com
Anthem(BCBS)/Aetna/Humana: https://availity.com
WEA Trust: https://www.weatrust.com

PREPARING A PRIOR-AUTHORIZATION: INS-AND-OUTS

- Most insurance companies will request clinical information to either be **faxed** or **uploaded through their portal** for review.
- Some insurance companies will ask you questions over the phone
  - If medical criteria is met based on the answers you provide, insurance will approve immediately.
- If you need to send clinical information for review, the insurance company will give you a pending reference/authorization number
  - Document this in the patient's account.

PRIOR AUTHORIZATION: NOT REQUIRED / NOT ELIGIBLE

**QUESTION:**
- What if you call or try to submit PA and the insurance company tells you authorization is not required?

**ANSWER:**
- **Submit for a pre-determination.**
  - This pre-determines the patient's benefits for the oral appliance.
  - Most policies are eligible for a pre-determination (this will then act as your approval).
  - If the insurance tells you the policy is not eligible for a pre-determination, make certain that you document!
  - Always get the representative’s name at the insurance company and a reference number for the call.
WAITING FOR APPROVAL: WE NEED TO TRACK OUR PATIENTS

- Now you wait to see if insurance approves.
- Track your patients- if they are coming in and you do not have authorization back, call the insurance company to check the status of the authorization request- this is where the pending reference/authorization number comes in handy.
- If the authorization has been approved, document the authorization number (may be the same number that was given to you at the pending status) and the valid date range.
- MAKE SURE PATIENT IS SCHEDULED TO BE FIT WITH THE ORAL APPLIANCE DURING THE VALID DATE RANGE.
- If the patient’s fit date does not fall within the valid date range, you will need to call to get an extension.
- If the authorization has been denied, the insurance company will tell you why denied.

WHAT IF PRIOR AUTHORIZATION IS DENIED?

If the authorization has been denied, the insurance company will tell you why denied.

COMMON DENIAL REASONS:

1. Patient must try CPAP trial for 45-60 days
   - Policy dependent (patients will not know this!)
   - You will not know this prior to receiving the denial.
   - “This is in the fine print” in the patient’s benefit handbook.
   - You cannot appeal this- it is the patient’s responsibility to then try CPAP for the recommended trial period- if after trial period patient cannot tolerate CPAP, then you will go through the authorization process again.
2. Oral appliance is a non-covered benefit under member’s plan (no appeal)
3. Patient does not meet medical criteria
   - This denial reason MAY be eligible for appeal typically a peer-to-peer review from your doctor to insurance company will overturn the denial and will then become approved.

WHAT IF PRIOR AUTHORIZATION IS DENIED - THE PEER TO PEER REVIEW?

Q: What is Peer-to-peer review?
A: Not to be confused with a medical peer review, this is solely something that happens when a request for services has been denied by the insurance company.

- This can also be called a “doc to doc” appeal, this is typically a phone conversation between a physician at an insurance company (the one that’s refusing to pay for services) and the patient’s attending physician or dentist (the one whose requesting services).
- Anyone on the patient’s team (physician, dentist, the patient him or herself) can initiate this with the insurance company when a request has been denied, but it’s infinitely better to make sure your doctor handles the conversation.
- Often times, getting the two doctors on the phone can make a world of difference to the initial denial.
- In our experience, the orientation is more along the lines of what is best for the patient NOT, how can we find an obscure reason to reject coverage for this procedure.
PRIOR-AUTHORIZATION IS APPROVED: LET’S TREAT THE OSA

- If the authorization has been approved and patient is scheduled, it is courteous to notify the patient ahead of time that:
  - Approval has been received and
  - What their estimated out of pocket will be for the oral appliance.
    - You will know the estimated out of pocket based on the benefits received from the insurance company at time of benefit verification and the allowable amount based on the contract with that insurance company.
- If the authorization has been approved and the patient is NOT scheduled, call patient & follow above steps.

AUTHORIZATION APPROVED: NOW WHAT?

- Patient returns for new patient appointment (the fabrication of the oral appliance)
- If you did not bill out a new patient exam at the free assessment visit, you can bill a new patient exam (e.g.: 99203 or 99204)
- If you bill for the office visit, your documentation must support (justify) that level of office visit that you are billing for.

  99201  $increasing complexity
  99202
  99203
  99204
  99205

AUTHORIZATION APPROVED: NOW WHAT?

- Depending upon the degree of complexity office visits (OV) can range from 99201-99205 (new patient) or 99211-99215 (established patient)
- You will need to document thoroughly for this appointment because upon claim submission and processing, the insurance company may request clinical information from your office to support the procedure that was billed.
- All the information you provided to obtain authorization must support this documentation.
CRITERIA TO QUALIFY FOR EACH LEVEL OF VISIT

- **99201-99205 (New patient visit)**
  - History, Exam & MDM must be met or exceeded
  - History: HPI (4), ROS (2-9), PFSH (1 of 3)
  - Exam: 2-7 systems/areas examined
  - MDM: 2 of 3 number of diagnoses, limited data reviewed, low risk of complications

- **99203**
  - History, Exam & MDM must be met or exceeded
  - History: HPI (4), ROS (10+), PFSH (3)
  - Exam: 8+ systems/areas examined
  - MDM: 2 of 3 number of diagnoses, limited data reviewed, low risk of complications

- **99204**
  - History, Exam & MDM must be met or exceeded
  - History: HPI (4), ROS (2-9), PFSH (1 of 3)
  - Exam: 2-7 systems/areas examined
  - MDM: 2 of 3 number of diagnoses, limited data reviewed, low risk of complications

- **99211-99215 (Established patient visit)**
  - History, Exam & MDM must be met or exceeded
  - History: HPI (1-3), ROS (1), PFSH (none)
  - Exam: 2-7 systems/areas examined
  - MDM: 2 of 3 number of diagnoses, limited data reviewed, low risk of complications

  - **99213**
    - History, Exam & MDM must be met or exceeded
    - History: HPI (4), ROS (2-9), PFSH (1 of 3)
    - Exam: 2-7 systems/areas examined
    - MDM: 2 of 3 number of diagnoses, limited data reviewed, low risk of complications

  - **99214**
    - History, Exam & MDM must be met or exceeded
    - History: HPI (4), ROS (2-9), PFSH (1 of 3)
    - Exam: 2-7 systems/areas examined
    - MDM: 2 of 3 number of diagnoses, limited data reviewed, low risk of complications

AUTHORIZATION NOT ON FILE

- What if patient wants to proceed with treatment without authorization on file?
  - This will pertain to those patients when the authorization is pending with insurance
  - You must have patient sign YOUR financial policy
  - Helpful to have patient sign additional form “waiver for treatment without valid authorization on file”
  - Continue to follow-up with insurance company
  - If authorization is denied yet patient agreed to treatment, patient is responsible for FULL amount
  - Lab fee for having appliance made – charge the patient if appliance not picked up

TREATMENT BEGINS: DELIVERY OF THE MANDIBULAR ADVANCEMENT DEVICE
TREATMENT BEGINS: DELIVERY OF THE MANDIBULAR ADVANCEMENT DEVICE (MAD)

• Patient returns for the ‘fitting’ of the custom fabricated oral appliance
  ○ Collect on the estimated portion due at this appointment
  ▶ Review your insurance contract to ensure your office can pre-collect
  ○ You MUST document thoroughly
  ○ Upon claims processing, insurance may request documentation to support medical necessity

• Bill for procedure code for oral appliance
  ○ Insurance companies may not allow an office visit to be billed additionally (bundle)

ORAL APPLIANCES FOR SLEEP APNEA...WHAT ARE THEY CALLED

• Oral Appliances
• Oral Devices
• Oral Sleep Appliance
• Dental Devices
• MAD "Mandibular Advancement Device"
• MRD "Mandibular Repositioning Device"
• MAS "Mandibular Advancement Splint"
• OAT "Oral Appliance Therapy"
• TRD "Tongue Retaining Device"

CLAIMS PROCESSING

• If the claim is paid, great, you do not need to do anything else
• If the claim is denied, you will need to follow-up appropriately to get the payment you deserve!
  ○ Your denial reason will be listed on EOB from insurance
  ○ Insurance may request records prior to processing claim (not yet denied)
QUESTIONS & ANSWERS
Thank you for attending the presentation!

Please feel free to ask questions!