The following comments/recommendations do not represent an official position by the Wisconsin Sleep Society.

The comments herein are a compilation of observations and consequent recommendations from my own personal experience and that of numerous dental offices involved in providing DSM therapy.

There are a number of consultants who specialize in medical reimbursement for DSM and I recommend that the dental office new to DSM consider employing such services for the first year or so of providing treatment of the nature.
This is MEDICAL people, and we are DENTAL, so we need a little help at first.

When you are just getting started, consider a Medical Billing service for the 1st year.

CMS 1500 Form

- Standard paper claim form used to submitted to a payer requesting reimbursement to a provider
- Claims may be submitted electronically using the same information submitted on the paper 1500 claim form

WE'VE GOT YOU COVERED FROM A TO PAID.
www.medicalbillingfordentists.com
When you are just getting started, consider a Medical Billing service for the 1st year.

www.niermanpm.com

When you are just getting started, consider a Medical Billing service for the 1st year.

www.dentalsleepsolutions.com

There is no debate: these things work!

Summary

- OATs may be effective in improving sleep parameters and outcomes of OSA, and there is little likelihood of harm.

- Although they are not as effective as PAP therapy, the benefits of using OAs outweigh risks of not using OAs.

- Thus, a “STANDARD” strength of recommendation to use OAs was provided.

“GRADING” Scheme: Assigning Strength of Recommendations

Recommendations: Summary

1. We recommend that sleep physicians prescribe oral appliances, rather than no therapy, for adult patients who request treatment of primary snoring (without obstructive sleep apnea). (STANDARD)

2. When oral appliance therapy is prescribed by a sleep physician for an adult patient with obstructive sleep apnea, we suggest that a qualified dentist use a custom, titratable appliance over non-custom oral devices. (GUIDELINE)

3. We recommend that sleep physicians consider prescription of oral appliances, rather than no treatment, for adult patients with obstructive sleep apnea who are intolerant of CPAP therapy or prefer alternate therapy. (STANDARD)
Recommendations (cont.):

4. We suggest that qualified dentists provide oversight—rather than no follow-up—of oral appliance therapy in adult patients with obstructive sleep apnea, to survey for dental-related side effects or occlusal changes and reduce their incidence. (GUIDELINE)

5. We suggest that sleep physicians conduct follow-up sleep testing to improve or confirm treatment efficacy, rather than conduct follow-up without sleep testing, for patients fitted with oral appliances. (GUIDELINE)

6. We suggest that sleep physicians and qualified dentists instruct adult patients treated with oral appliances for obstructive sleep apnea to return for periodic office visits—as opposed to no follow-up—with a qualified dentist and a sleep physician. (GUIDELINE)


Getting paid: Insurance Basics

2 Types of codes used for medical insurance
1. DIAGNOSIS CODES:
   ICD-10: (International Classification of Diseases) – “what’s broken”

2. TREATMENT CODES:
   CPT: (Current Procedural Terminology) – “What you did to fix it”

Medicare Writes the Rules

THE ELEVENTH COMMANDMENT
Thou Shalt Listen to Medicare
Must-have references

- International Classification of Diseases: 10th Revision (ICD-10)
- International Classification of Sleep Disorders: 3rd Edition (ICSD-3)
- Procedural Coding Manuals
  - Health Care Common Procedural Coding System (HCPCS, Level II)

Diagnosis Codes

- The most common billable diagnostic code for DSM cases:
  - G47.33 : “Obstructive Sleep Apnea w/Hypersomnia”

- Another common billable diagnostic code for DSM cases if using Acoustic Reflection is:
  - Q38.2 : “Macroglossia”

- You can put up to 4 ICD codes on the claim form always put G47.33 first, as the primary diagnosis.
Medical Terms Frequently Encountered

- Obstructive Sleep Apnea (OSA)
- Apnea & Hypopnea (A) (H)
- Apnea-Hypopnea Index (AHI)
- Polysomnogram (PSG)
  - Diagnostic
  - Split Night Study with CPAP Titration
- Home Sleep (Apnea) Test (HSAT, aka: HST)

Insurance Terms Frequently Encountered

- **Premium**
  The fee paid to maintain the health insurance and is paid monthly or annually
- **Deductible**
  An additional cost that the policy holder will also incur.
  Set amount the insured person must pay before the benefits of the policy start
- **Copayment or Coinsurance**
  Costs charged to the policy holder for office visits and other services

Pre-certification
- Process of confirming with an insurer that a test or procedure is a covered service paid for by the insurer

Pre-Authorization
- Process of confirming with an insurer about a covered service so we whether or not it is considered medically necessary for the patient

Pre-Determination
- Process of determining how much an insurer will pay for a given test or procedure
Effective July 1, 2012 the accepted coding for Oral Appliances used for the treatment of Obstructive Sleep Apnea (OAOSA) is E0486.

- Only oral appliances used for the treatment of obstructive sleep apnea (OSA) that fulfills the definition of durable medical equipment (DME) are eligible for Medicare reimbursement by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

- Definition of Durable Medical Equipment (DME):
  - is any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses.

www.dmepdac.com/resources/articles/2012/07_12_12.html

So, what is required for an OAT to fulfill the criteria of a DME (E0486)?

1. Code E0486 may only be used for custom fabricated mandibular advancement devices
2. Have a fixed mechanical hinge (see below) at the sides, front or palate
3. Be able to protrude the mandible beyond the front teeth when adjusted to maximum protrusion
4. Incorporate a mechanism that allows the mandible to be easily advanced by the beneficiary in increments of one millimeter or less

www.dmepdac.com/resources/articles/2012/07_12_12.html

DME (E0486) cont.

- Retain the adjustment setting when removed from the mouth, and
- Maintain the adjusted mouth position during sleep, and
- Remain fixed in place during sleep so as to prevent dislodging the device, and
- Require no return dental visits beyond the initial 90-day fitting...in order to maintain effectiveness

www.dmepdac.com/resources/articles/2012/07_12_12.html
**Fixed Mechanical Hinge at the sides**

**Herbst (Mechanism) EMA (Durometers)**

- A fixed mechanical hinge: *a mechanical joint containing an inseparable pivot point.
- Interlocking flanges, tongue and groove mechanisms, hook and loop or hook and eye clasps, elastic straps or bands, etc. do not meet this requirement*

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**DSM REIMBURSEMENT STEP-BY-STEP**

**Screening* appointment w/ PSG on file:**

- If PSG on file, verify benefits with patient’s medical insurance
- ALL insurance companies will require authorization for oral appliance so get the phone# for the authorization dept
- Authorization cannot be done until after the screening* appointment
- Since PSG on file, schedule patient for follow-up appointment at least 2 weeks from screening appointment

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**DSM REIMBURSEMENT STEP-BY-STEP**

- If PSG is NOT on file because it is never been done, you will need to make arrangements for a PSG or HST to be performed and scored.
- You will have to contact PCP for a formal request for PSG/HST to be performed
- After that has been arranged, you can essentially take over the management of the patient
- If you refer the patient to his/PCP to manage this, make certain that:
  - The patient is scheduled with your office to return for OAT
  - Inform the PCP that you would appreciate his/her office referring the patient back to you with the proper referral form * because the patient want to proceed with OAT
  - Allow a minimum of 6-8 weeks for the patient to have the PSG/HST – SCORING, and in some cases (insurance company-specified), CPAP trial/intolerance must be accomplished FIRST!
Contact insurance company to submit for authorization for oral appliance

- If no authorization is required for the oral appliance, ALWAYS ask to submit for a predetermination that way you have something in writing that the oral appliance is a covered benefit under the patient’s policy.

You will need to submit clinical information to the insurance company for their review:

- Include your request in writing, the PSG, office notes, affidavit for non-tolerance of CPAP (if applicable)
- Keep your fax confirmation & document patient’s account.

IF AUTHORIZATION IS DENIED

- If authorization has been denied, follow the denial letter to appeal
  - Peer to peer review
  - Letter of medical necessity from ordering doctor to support medical necessity

Member appeal

- Response from the insurance company for approval/denial of authorization is typically 2 weeks from date of submission- call them to f/u on the status
- Some policies (which are written in the patient’s benefits) may require use of CPAP prior to coverage of oral appliance
- If a patient has tried a CPAP and failed, it is helpful to have the patient complete an affidavit of non-tolerance to CPAP at their first appointment.
- This needs to be submitted to the insurance company when authorization has been initiated.
New Patient

No Previous DX

Previous DX

(HST/PSG)

Suspect SDAB
- review our exam notes
- discuss related concerns
- provide clinical notes

Suspect SDAB co-morbidities
- Cardiovascular disease
- Insomnia
- RLS/PLMDS

Request Medical Directive (Rx) for HST

Review Test Results/Diagnosis

Consultation/Exam

Arrange HST/PSG w/ Testing Facility

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**Initial Sleep “Screening” Forms**

**Review of Systems**: Critical for higher level reimbursement!
Letter of Medical Necessity for Oral Appliance

- This is essentially a ‘prescription’ for an oral appliance written from the primary care physician to the dentist.
- This is for insurance reasons also. (Especially HMO).
Evaluation and Management

- Evaluation and Management (E&M) are CPT codes that describe services provided by dentists
  - Patient visits the dentist with an illness typically described as obstructive sleep apnea
  - Dentist takes patient history, provides exam and determines if they are a candidate for oral appliance therapy
  - Additional tests or procedures may require other additional codes
E and M Codes in Dental Sleep Medicine

• Two ranges for office visits
  - New Patient Office Visits: 99201-99205
  - Established Patient Office Visits: 99211-99215

Cost selection is based on the level of service and describes the extent and type of evaluation and treatment provided during the office visit.

Defining: “New” & “Established”

New and Established Patients

• New Patient: Within the past three (3) years this patient has not received professional services from the physician he/she is seeing or from another physician in the same group.

• Established Patient: Within the past three (3) years this patient has received professional services either from the physician he/she is seeing or from another physician in the same group.

Documentation Guidelines for Evaluation and Management Services:

- New Patient

[Diagram of documentation guidelines]
**ICD 10 CM & CPT Codes, Fees, and Time Units, Approximate Fees for OAT for OSA (G47.33)**

<table>
<thead>
<tr>
<th>Description of Service</th>
<th>ICD-10 CM Code</th>
<th>CPT code</th>
<th>Fee Range</th>
<th>Time (mins.)</th>
<th>Estimated Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Examination of the Dental Sleep Medicine Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Sleep Screening – Consultation (New Patient)</td>
<td>NA</td>
<td>NA</td>
<td>$0–$50</td>
<td>30–60</td>
<td>$50–$100</td>
</tr>
<tr>
<td>2. Comprehensive Consultation</td>
<td>G47.33</td>
<td>99212</td>
<td>$115–$150</td>
<td>40–60</td>
<td>$50–$100</td>
</tr>
<tr>
<td>Radiographic Examination (Options)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Cone Beam - Two-Dimensional Image Reconstruction using existing data includes multiple images</td>
<td>G47.33</td>
<td>70486</td>
<td>$50–$950</td>
<td>20*</td>
<td>$50–$950</td>
</tr>
<tr>
<td>2. Cephalometric Film</td>
<td>G47.33</td>
<td>70350</td>
<td>$100</td>
<td>10*</td>
<td>$50–$100</td>
</tr>
<tr>
<td>3. Panoramic Film</td>
<td>G47.33</td>
<td>70355</td>
<td>$200</td>
<td>10*</td>
<td>$40–$100</td>
</tr>
<tr>
<td>Laryngeal Function Study (Pharyngometry)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Acoustic Pharyngometry</td>
<td>Q38.2</td>
<td>92520</td>
<td>$250</td>
<td>30*</td>
<td>$100–$200</td>
</tr>
<tr>
<td>2. High upper airway study</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Oraluction</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Assessment</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*We most often bill for 99213 which is designated as a "Established Patient Visit".

**ICD 10 CM Codes and Approximate Fees for OAT for OSA (G47.33)**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10 CM Code</th>
<th>CPT code</th>
<th>Fee Range</th>
<th>Time (mins.)</th>
<th>Estimated Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating the Dental Sleep Medicine Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Appliance Delivery</td>
<td>E0486</td>
<td>G47.33</td>
<td>$1500–$9000</td>
<td>45</td>
<td>$900–$6600</td>
</tr>
<tr>
<td>Established Patient Visit</td>
<td>99213</td>
<td>G47.33</td>
<td>$115–$150</td>
<td>30</td>
<td>$95–$150</td>
</tr>
<tr>
<td>Follow-up Care Office Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 1 week check</td>
<td>99212</td>
<td>G47.33</td>
<td>$115–$150</td>
<td>30</td>
<td>$95–$150</td>
</tr>
<tr>
<td>2. 1 month Established Patient Visit</td>
<td>99213</td>
<td>G47.33</td>
<td>$115–$150</td>
<td>30</td>
<td>$95–$150</td>
</tr>
<tr>
<td>3. 2 month Established Patient Visit</td>
<td>99213</td>
<td>G47.33</td>
<td>$115–$150</td>
<td>30</td>
<td>$95–$150</td>
</tr>
<tr>
<td>4. 3 month Established Patient Visit</td>
<td>99213</td>
<td>G47.33</td>
<td>$115–$150</td>
<td>30</td>
<td>$95–$150</td>
</tr>
<tr>
<td>5. 6 month Established Patient Visit</td>
<td>99213</td>
<td>G47.33</td>
<td>$115–$150</td>
<td>30</td>
<td>$95–$150</td>
</tr>
<tr>
<td>6. 12 month Established Patient Visit</td>
<td>99213</td>
<td>G47.33</td>
<td>$115–$150</td>
<td>30</td>
<td>$95–$150</td>
</tr>
</tbody>
</table>
ICD 10 CM Codes and Approximate Fees for OAT for OSA (G47.33)

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10 CM Code</th>
<th>CPT code</th>
<th>Fee Range</th>
<th>Time (mins.)</th>
<th>Estimated Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we do not offer “global fees” for OAT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. 1 week check</td>
<td>99202</td>
<td>99212</td>
<td>$45 – 75</td>
<td>20-30</td>
<td>$30 – 55</td>
</tr>
<tr>
<td>2. 1 month Established Patient Visit</td>
<td>99203</td>
<td>99213</td>
<td>$115 – 150</td>
<td>30</td>
<td>$95-$150</td>
</tr>
<tr>
<td>3. 2 month Established Patient Visit</td>
<td>99203</td>
<td>99213</td>
<td>$115 – 150</td>
<td>30</td>
<td>$95-$150</td>
</tr>
<tr>
<td>4. 3 month Established Patient Visit</td>
<td>99203</td>
<td>99213</td>
<td>$115 – 150</td>
<td>30</td>
<td>$95-$150</td>
</tr>
<tr>
<td>5. 6 month Established Patient Visit</td>
<td>99203</td>
<td>99213</td>
<td>$115 – 150</td>
<td>30</td>
<td>$95-$150</td>
</tr>
<tr>
<td>6. 12 month Established Patient Visit</td>
<td>99203</td>
<td>99213</td>
<td>$115 – 150</td>
<td>30</td>
<td>$95-$150</td>
</tr>
<tr>
<td>Total charges (costumed) Evaluation of Established Patients</td>
<td>99203</td>
<td>$660</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If we charge a level 3 each time, assuming a modest reimbursement level of $60:

Remember:

✓ You must have sufficient documentation in order to support the level for which you are billing

✓ If you do not, this will often trigger a “request for review of records”

Every visit warrants a charge -NO GLOBAL FEES-
Every visit warrants a charge
-NO GLOBAL FEES-

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>DESCRIPTION OF SERVICES</th>
<th>AMOUNT CHARGED</th>
<th>NOT COVERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>Cerebral Palsy Visit</td>
<td>$300.00</td>
<td></td>
</tr>
<tr>
<td>90072</td>
<td>Pharyngotomy</td>
<td>$200.00</td>
<td>1-20 mL</td>
</tr>
<tr>
<td>90271</td>
<td>Pharyngotomy</td>
<td>$200.00</td>
<td>10-39 mL</td>
</tr>
</tbody>
</table>

| TOTAL SUBTOTAL | $600.00 |

<table>
<thead>
<tr>
<th>PAID TO PROVIDER</th>
<th></th>
<th>PATIENTDED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$100.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$500.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$100.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$500.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$600.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Don’t submit low fees!

- It's good that it was paid, but they would have likely paid more.
- Insurance companies typically adjust every fee down to an "allowable" amount
- If they pay 100% of a fee you bill it means their allowable was more than what you billed.
Some will be more, some will be less.

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Type of Service</th>
<th>Total Pldd.</th>
<th>Patient Payment</th>
<th>Deductible</th>
<th>Other</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/18/2013</td>
<td>Office Visit</td>
<td>$100.00</td>
<td>$10.00</td>
<td>$0.00</td>
<td>$70.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>09/21/2013</td>
<td>Visit</td>
<td>$50.00</td>
<td>$5.00</td>
<td>$0.00</td>
<td>$45.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

TOTAL PAID CLAIM: $55,809.00 $0.00 $710.00 $605.00 $27.86 $5,277.14

If you are not in network, you have to bill a sufficient amount until you learn what they will pay!
UHC was billed for $6500 and they paid $6500! Again, what might this indicate?

If you are **not** in network, you have to bill a sufficient amount until you learn what they will pay!

**Codes & Fees for a typical case**

- Initial Consultation/Evaluation (1 hour) ........................................... $ N/C
- Comprehensive Exam (1 hour) ........................................... 99214
  - Radiographic Film (with interpretation) ........................................... 76002
  - Cephalometric Film ........................................... T0350
  - Panoramic Film ........................................... T0355
- Appliance Delivery (45 minutes) ...........................................
- Oral Appliance .................................................................. E0486
- Established Patient Visit ........................................... 99213
- Follow-up Care Office Visits (30 minutes) .........................
  - 1 week check ........................................... N/C
  - 1 month Established Patient Visit (30 minutes) ....................... 99213
  - 3 month Established Patient Visit (30 minutes) ....................... 99213
  - 6 month Established Patient Visit (30 minutes) ....................... 99213
  - 12 month Established Patient Visit (30 minutes) ...................... 99213
- Annual Established Patient Visits (30 minutes) ....................... 99213