

Medical Insurance Billing for Oral Appliance Therapy

The **MYSTERY** of Dental Sleep Medicine Billing **REVEALED**

*(for smart, ethical and moral dental teams who want to help
lots of people and keep their dentist out of jail)*



By Jenni Spencer

With Rose Mary Milner

and Foreword by Dr. Jamison Spencer

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For information or questions about Spencer Study Club or the content in this book, please email jenni@jamisonspencer.com or go to www.JamisonSpencer.com.

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Legalese

The information provided in this book is meant to inform and educate you on methods of accepting and billing medical insurance for dental sleep medicine in your dental practice. It is correct to the best of our knowledge and experience as of the date published, or the dates of revision. It is not meant to offer you legal advice or to be considered an all-inclusive source of insurance information. Insurance companies (including Medicare) change their practices and requirements all the time, so it is the reader's responsibility to verify that the practices in this book are still correct.

Proceed at your own risk...

Acknowledgements

Since it's a known fact that most people skip over the book acknowledgements, I'll keep them super brief ;-D....

Thanks RoseMary for proofing, editing, teaching and helping me create this book—You are an insurance wizard! And to Mallory for helping fine tune a few insurance pearls.

I would be totally remiss if I didn't offer a shout out to Dr. Ellen Crean. Many of the graphics and charts you see in this book are from her excellent presentation on billing medical insurance for Dental Sleep Medicine (which is part of "Spencer Study Club"). I so appreciate you letting me use them Ellen!!

A big thank you to our amazing illustrators at Mikoarc (<http://www.mikoarc.blogspot.com>). They were fun to work with and did a great job of making my little avatars look amazing ;-D! Too much fun!

Thanks Jamison for encouraging me to take on this project and for having faith that I could write it!

And finally, thanks to you, our reader! Jamison and I want you to help as many patients as possible to receive the care they need and improve their quality of life (while keeping your doctor out of jail and out of insurance reviews!). So thanks for putting your trust in us. When you discover your own little insurance pearls, we'd love to hear them and include them in future revisions, as I expect we'll be making updates to this little project as things change. Feel free to email me at Jenni@JamisonSpencer.com.

Now to the meat of it!

Foreword

By Dr. Jamison Spencer

After every lecture I'm asked the same 3 things:

1. How did you get to be so incredibly awesome, yet remain so humble?
2. Where do I learn more about this TMD/Sleep Apnea stuff?
3. How do I bill for oral appliance therapy for Sleep Apnea?

Ok...maybe I don't get asked #1 very often; but I get asked #2 & #3 literally every time. To address the second question of where to learn more about TMD and Oral Appliance Therapy, we've created Spencer Study Club (learn more at www.JamisonSpencer.com). And to address question #3, Jenni, my unbelievably fantastic wife of 25 years, took on the task to put together this book.

So why not just direct you to a billing company? We *strongly* encourage dental offices just getting started, or those ready to really ramp up dental sleep medicine in their practices, to work with a billing company. *However*, not all billing companies are created equal, and *many* of them are teaching dentists to do incorrect things that could literally lose the dentist her or his license, or even wind them up in jail. And then there are some "billing companies" that are just crooks.

So how will you know who to work with, or if you need to work with anyone at all?

That's the point of this book. We hope that the "secrets" shared within these covers allow you to become educated about the basics, and not so basics, of dental sleep medicine billing. If you understand the correct principles you will know what questions to ask and how to evaluate a possible billing company that you will *trust with your reputation*.

Or, maybe you decide to go it alone. That's probably a little harder, longer road, but on the other hand, no one cares about your practice as much as you do.

So whether you want to work with a *reputable* billing company, or do things on your own, this book will help you to know enough to know what you're supposed to know, what you need to know, and what some people don't want you to know.

Let me point out my **top 3 favorite disreputable billing schemes** as of this edition (the scammers are always working hard at newer and better scams...so these may be old news within just a few months of publication):

1. Bill the insurance company 6K (or more...often *way* more) *out-of-network* and just tell the patient, "don't worry, we'll just accept whatever the insurance pays," or "don't worry, you'll only owe us \$X at the most...but if your insurance pays a lot you might not owe us anything." A slight variation of the first scheme that I recently heard of was the "billing company" doing this, but then contracting with the dentist to give the dentist a certain amount...say up to a maximum of \$2500. The company bills a fortune, and then keeps anything above and beyond the amount they give to the dentist. So, in other words, they use the dentist to fleece the insurance company, but of course it will be the dentist who will be liable for the fraud once charges are filed. "Ignorance is not a defense."

Now, if you are a dentist or work for a dentist you're probably thinking, "you can't do that!," and you'd be 100% correct. Four out of five dentists surveyed would likely think that is insurance fraud (and the 1 who doesn't also believes flossing is bad for you). This billing scheme is based on the *myth* that if you are "out-of-network" you can bill the insurance company anything you want, and you and the patient have zero accountability. Wrong. And in some states, this could literally lose your doctor their license or wind them up behind bars.

2. You "screen" the patient and have them get a home sleep test mailed to them, apparently ordered either by your dentist, or by some MD who is not only most likely out of state but who also has no actual contact with the patient. The home study is read by this "board certified sleep doctor" and then the report is sent back to the dentist, usually with a prescription for the oral appliance. A variation on this theme has the home sleep testing company contact your patient's family care doctor to try to talk her/him in to writing a script for the oral appliance. This same company will handle all of the billing...and usually will employ scheme #1 as part of their overall plan.

So this one almost feels like it could really help you not have to go through all that effort of working with your local medical community, and your patient doesn't have to talk with an actual MD who would waste time looking at silly comorbidities such as high blood pressure, diabetes, mood disorders, or excessive daytime sleepiness that could result in the patient doing something wrong/dangerous at work, or just falling asleep at the wheel of the school bus they drive (in case you can't tell...I'm being sarcastic).

3. The mail order appliance! No, I'm not talking about the "boil and bite" oral appliances you've seen on TV...those are cash pay. I'm talking about a company that literally sends the patients (including Medicare patients) putty impression materials for them to take their own impressions and bite records (I don't think they actually use bite records) so they can send them into the company to have a soft suck down with velcro and Herbst arms on it custom made for them and delivered back to them in the mail. And, of course, they handle all of the billing of the insurance company for the patient (including contacting their MD for an Rx). Who needs us dentists involved at all?!!

And, of course, this appliance can't possibly result in any untoward side effects such as tooth movement, bite changes, jaw pain, periodontal bone loss, dislodgment of restorations, etc.. Right?? Well, I guess if it does then the patient can mail their teeth/jaws back to the company and have them help fix the problems. (Sarcasm again.)

Now I tell you these things to make you aware that:

1. **This stuff is likely going on in the state you live in right now!** Often, in my experience, the dentist who has contracted with a billing company that employs one of these schemes actually has no idea that anything is being done that is wrong or questionable.
2. **The insurance companies and often the medical doctors sometimes can't tell the "good guys" from the "bad guys."** I've had an experience where a major insurance company basically banned oral appliance therapy due to the billing practices of a few dentists. Luckily, we were able to turn that around.
3. **It is up to YOU to not only be one of the "good guys" but to make your local insurance companies and medical doctors aware that oral appliance therapy can be done in an ethical, moral and affordable manner, and that patients usually have excellent outcomes.**

If you're super offended by what I've written so far since this is *exactly* what you do in your office and you think it's the best thing ever; this book isn't for you, and I encourage you to just sell off your Dental Sleep Medicine scam now before you end up on an episode of "American Greed." I will be more than happy to refund any money that you paid for this book...because I don't want to be associated with you in any way.

However, **I'll bet that you are actually an honest, good hearted dentist (or work for one), and are looking to help more of your patients, by helping make oral appliance therapy more affordable to them.** If that's true, then you're in the right place. Working with medical insurance will significantly increase the number of your patients that you are able to help. Many of our patients pay little, and sometimes nothing, out of pocket for their care, the insurance companies refer patients to us, and we are respected in our medical and dental communities. We want that for you too.

Now let me introduce you to your host; the most incredible person I know; mother of 6; and complete dental sleep medicine billing **novice**...Jenni Spencer.

***Common Sense Disclaimer:** Insurance rules change faster than politicians change their positions. We will strive to keep this book up to date...but if you **really** want to be certain that you are doing things 100% the right way, please consider working with one of the reputable billing companies.*

*Also, insurance company's rules vary by policy within the main company's policy...so there are **never** guarantees. Medicaid is state to state. Medicare has specific regions. This is more complicated than the sport of Cricket, and just as understandable to a beginner (if you've never watched Cricket, YouTube a match and you'll know what I mean). And, just when you think you've got a grip, they give you new codes, new guidelines, or a new medical director shows up and decides to do things "their way."*

So remember...it is up to you to do things right. Hopefully this will help you get started.

Introduction

Welcome to my world—the world of knowing nothing about billing medical insurance. That’s right. I am just like you. I have no experience billing anything to medical insurance. So you might ask yourself, “Why am I putting my future medical billing life into this crazy lady’s hands?” Before you answer that question (and toss this book into your perfectly positioned wastepaper basket), let me tell you a quick story...

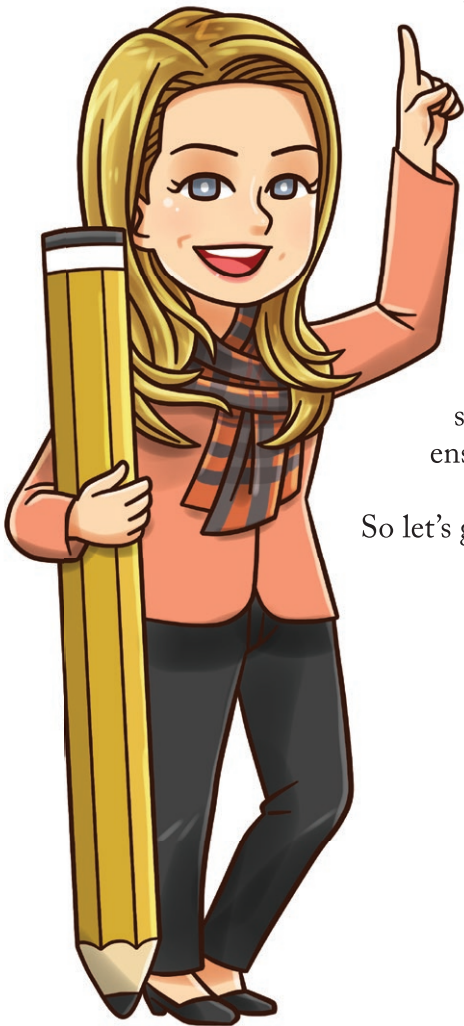
Jamison and I have long envisioned an easy to follow, step by step guidebook to help dental practices, like yours, bill medical insurance for helping their patients with oral appliance therapy. Let’s face it, there are a lot of people out there telling you to bill this code or that code. Some are well meaning, and some are downright unethical and could end your doctor up in jail. We wanted something easy, but also above reproach—putting you above the scrutiny of all insurance fraud departments.

Our book journey took us down several paths, most of which had very knowledgeable medical billing people writing drafts of a book that I could not understand. Although I’ve never billed insurance (dental or medical) I’ve been around the terminology for 18 years through Jamison’s practice. If I couldn’t understand it, then how could a complete newbie figure it out? Now granted, **you are probably not a complete newbie**. Maybe you’ve already been billing dental insurance for years—in which case you are

way ahead of me! Or maybe you’ve been billing medical insurance for a little while and just want to make sure you are doing it correctly and ethically. Feel free to skip around then, and get the pearls that you need. For the rest of us, back to my story...

That’s when Jamison had an epiphany of sorts (he’s always doing that!)—I should write the book. My insurance-free background is a huge gift! My inexperience will ensure that I have the same questions that you have, wonder about the same codes that you do, and probably need a spoon-fed, barebones approach to billing medical insurance in order to get it done. Thankfully I am surrounded by medical billing experts at all of Jamison’s practices to ensure that I don’t mess up and steer you wrong.

So let’s get started on this fun journey together...woo hoo!!



[illegible]

The Prep Work

Your “Get Started” Checklist....

If you're like me, you love checking things off your list! Here is a list of things you'll need to do in order to be ready to bill medical insurance for dental sleep medicine.

☐ **Obtaining your NPI (National Provider Identifier)**

You probably already have this (Nice! You're checking things off already!). If you don't, in order for the insurance companies to identify your practice as an entity they can pay, you have to have a provider number. In insurance circles it's called an NPI or National Provider Identifier and is required by HIPAA (Health Insurance Portability and Accountability Act of 1996). The good news is that this is a pretty easy process and it's usually fast.

To apply for an NPI, go to <https://nppes.cms.hhs.gov/>. You will create a login and follow the instructions for individual providers or “Apply for your personal NPI Record.” It should only take about 20 minutes, and then you'll be good to go!

☐ **Order/Purchase HCFA forms**

Some insurance companies accept claims printed straight from your computer, but some require pre-printed forms (your computer just fills in the blanks). This is because some insurance companies (including Medicare) use a “drop ink” technology that allows their computer system to scan preprinted HCFA (Health Care Finance Administration) forms, eliminate the special red ink of the form and translate the essential information into their system. To make it easy on yourself, I suggest just using preprinted forms for all insurance claims. There are several places online that you can get them, even Amazon Prime has them for around \$15.00—listed under “NEW CMS 1500 Claim Forms - HCFA version (02/12) (500 Sheets)”, or you can buy them at Staples. Make sure you do not get the forms that are version (08-05) as they will not be accepted.

☐ **Download a HCFA/CMS 1500 Form Template**

Now that you've ordered your forms you need some kind of template to fill them in for you. Many dental insurance billing programs have the ability to fill in the HCFA forms, so I would start there and see if your program does this. If yours does, score! You've checked off another box! If not, you have a couple options. You can fill them out by hand, or there are a bunch of templates on the internet you can download. Some are free, some are not. Find ones that you like and experiment with them.

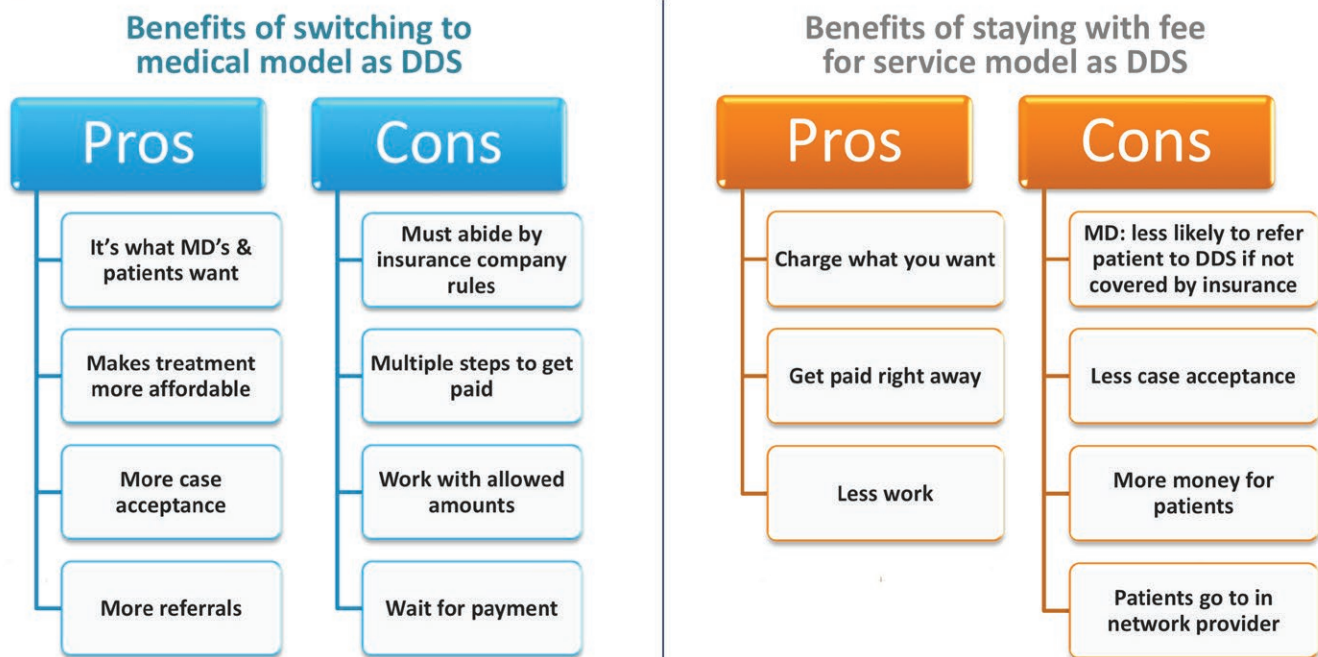
☐ **To Contract or not to Contract (With Insurance)**

This is a tough question! To answer this question you will need to take a deep, hard look at many different factors, such as your area, your referral sources (if any), your local insurance companies and their policies, etc.. Keep in mind that an insurance company cannot deny payment to a dentist, based on the fact that they are not a medical doctor (as long as the codes you are billing are covered benefits). Jamison and I have operated our practice from many different insurance perspectives—

- Cash basis where patients submit their own insurance claims and we get paid at time of service
- Billing our patients' insurance as "out-of-network providers" as a service to them, and
- Contracting with most insurance companies, including Medicare and Medicaid, to provide care for the greatest number of people.

To help you make the decision that is right for you, here is chart with some things for you to consider...

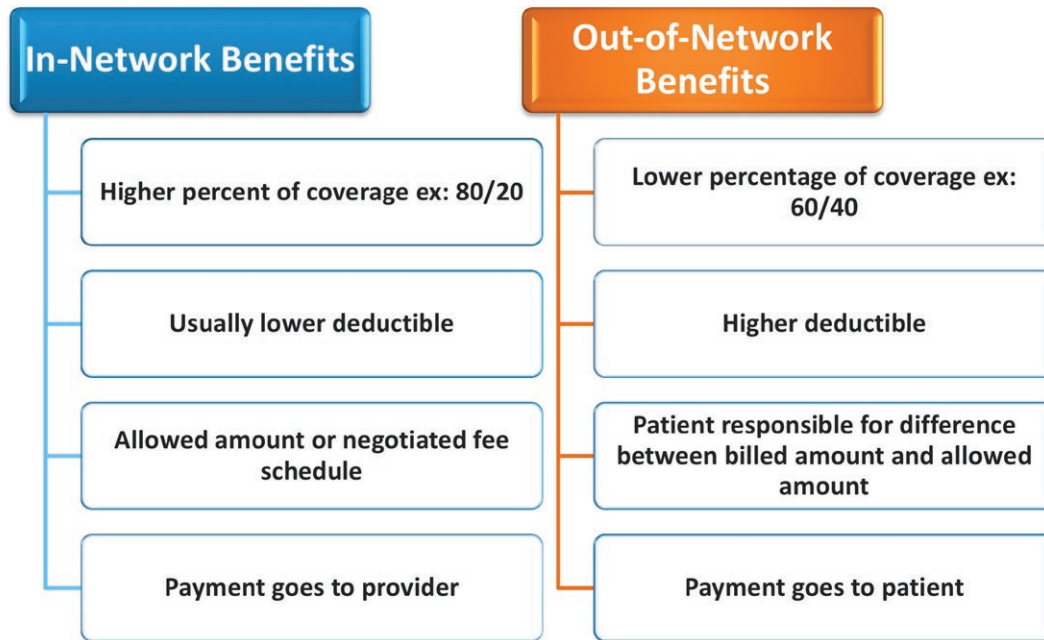
Medical Model vs. Fee for Service Model



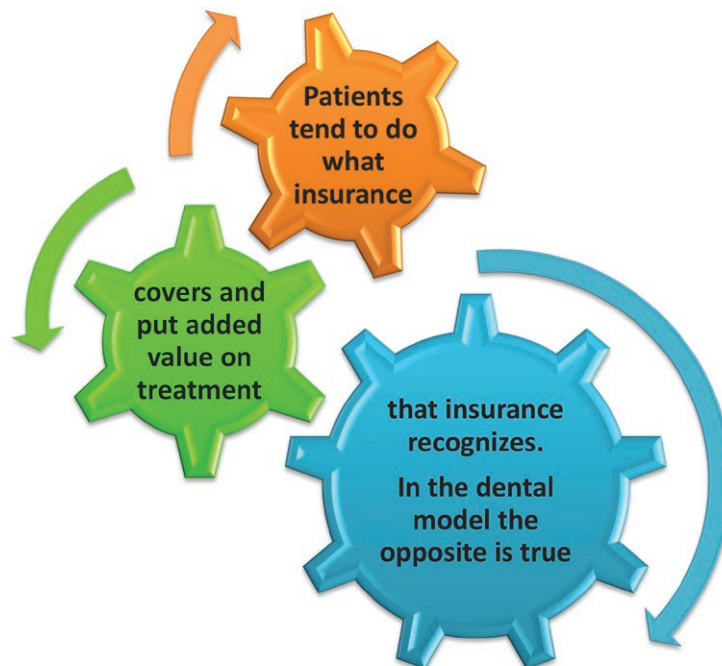
Other things to consider:

- What are other dentists in your area doing with regard to medical billing?
- Are there very many dentists in your area providing OAT?
- What relationships do you already have with insurance companies?
- What is your capacity to see more patients?
- How many sleep patients would you like to see per month?
- How many staff do you want to have?
- Do you currently have staff that are experienced with medical billing?
- Do you want to have a relationship with a billing company?
- Do you accept any dental insurance? If so, do most of your patients tend to only do things that are covered by their insurance?
- If you already have relationships with sleep doctors and/or other medical doctors, are they in-network with insurance and Medicare? If so, do they feel it's important for you to be?
- Many patients tend to do what their medical insurance covers and they put added value on treatment that their insurance covers.

In-Network Benefits vs. Out-of-Network Benefits



Patient Perspective of Medical Insurance



Acronyms & Definitions

Term/Acronym	Definition
Accept Assignment	If you want the insurance company to pay you directly instead of reimburse the patient, then you “accept assignment” for that claim. There is a little box on the HCFA form that you check if you want to accept assignment. Keep in mind that “Medicare style” accepting assignment is a whole different animal—although the payments are still sent to you instead of to the patient, there are other rules you must follow. (see Accepting Assignment under the Medicare Part B section)
CMN	A Certificate of Medical Necessity is required by some insurance companies, created by the referring provider or by your office that states why the treatment is medically necessary—this is also sometimes called a “letter of medical necessity.”
CMS	An acronym for Center for Medicare & Medicaid Services
CPAP	Continuous Positive Airway Pressure (traditional therapy for OSA)
CPT Code	Common Procedural Terminology codes are used to describe and bill evaluations, radiology, and other procedures. CPT codes are used in conjunction with ICD-10 (diagnostic) Codes.
CT	Cat Scan or Computerized Axial Tomography
CY	Calendar Year
DME	Oral appliances are considered DME or Durable Medical Equipment by most insurers. This is in contrast to regular medical services such as exams and other procedures. DME is billed using HCPCS codes.
DSM	Dental Sleep Medicine
DWO	Detailed Written Order
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
Fair Health	A website that can help you determine if your fees are within the usual, customary and reasonable (UCR) range for your area: http://fairhealthconsumer.org/whoweare.php . This site includes Medical and Dental Codes, contains data for all 50 United States, and is updated twice a year.
HBP / HTN	High blood pressure / Hypertension
HCFA	Health Care Financing Administration
HCPCS Code	Healthcare Common Procedure Coding System codes are used mainly for the DME portion of treatment. Medical CPT codes are used to bill other services.
HIPAA	Health Insurance Portability and Accountability Act
HST	Home Sleep Test (The patient wears a portable Sleep Monitoring unit at home)

Term/Acronym Definition

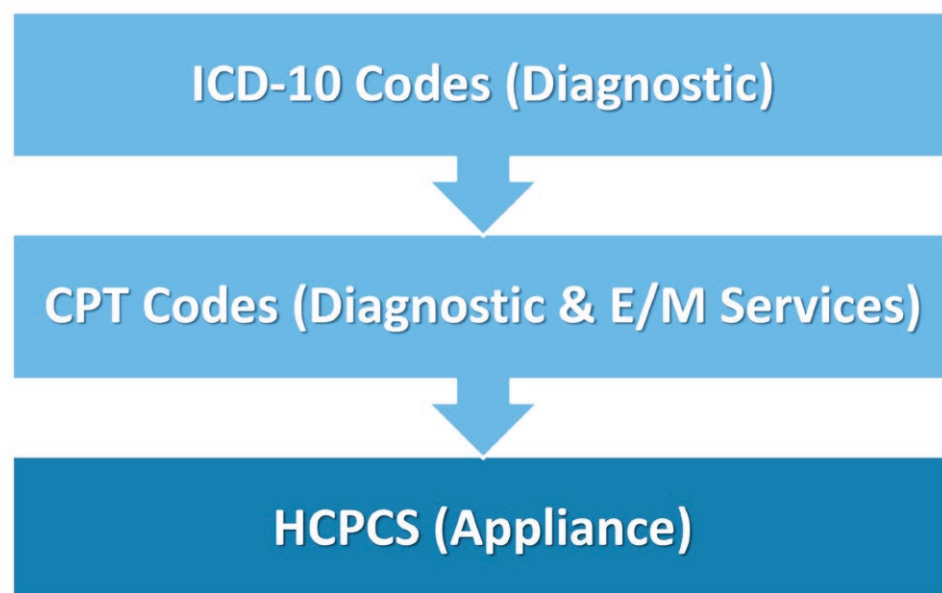
ICD-10 Codes	ICD-10 stands for International Classification of Diseases (or Diagnosis Codes). They are alpha-numeric codes that classify diseases, signs, symptoms, complaints, and external causes of injury or disease. The codes are three to six characters. Similar diseases start with the same numbers, and the basic diagnosis is the first 3 digits, followed by a decimal. The decimal part of the code gives more specific information about the diagnosis.
LCD	Local Coverage Determination; basically Medicare's rules for a specific treatment or code
Letter of Medical Necessity	A letter for the insurance company, created by the referring provider or by your office that states why the treatment is medically necessary—this is also sometimes called a “CMN” or Certificate of Medical Necessity.
Medicare Advantage Plan (Part C)	Medicare part C are the Medicare Advantage plans. They are private company policies that must provide the "equivalent" to regular Medicare, but their rules and coverage can vary greatly.
Medicare Assignment	Medicare payment goes directly to the provider. As the provider, you must collect deductible and co-insurance amounts. You can bill up to the Medicare Fee Schedule (MFS) amount, less payments made by the secondary insurer.
Medicare Participating Provider	A practice that agrees to Medicare's fee schedule and accepts assignment. There are advantages and disadvantages to being a participating provider.
Medicare Waiver/Advance Patient Notice (ABN)	An ABN is a written notice from Medicare (standard government form CMS-R-131), you give the patient before they receive services, notifying them that Medicare may deny payment for that specific procedure or treatment and that they will be personally responsible for full payment if Medicare denies payment.
MFS	Medicare Fee Schedule
MSLT	Multiple Sleep Latency Test
MSN	Medicare Summary Notice (Medicare sends to patient)
MSP	Medicare as a Secondary Payer
MSP Assignment	You may bill the patient up to the Medicare fee schedule, minus payments made by the primary and secondary insurance
MSP Participating Provider	May bill the patient an amount up to the Medicare fee schedule allowance.
Non Par	Non participating providers (Medicare Term)
NPI	National Provider Identifier
OA	Oral Appliance
OAT	Oral Appliance Therapy
OON	Out of Network Provider

Term/Acronym	Definition
OOP	Out of pocket expense (for the patient)
OSA	Obstructive Sleep Apnea
Peer to Peer Review	You can request a doctor who works with the insurance company look at the claim during the appeal process, and discuss your claim with the doctor to help explain the case in more detail or get guidance on what needs to happen to have the claim approved.
Pre-Authorization	The insurance company hoops you have to jump through before the patient is seen, in order for the insurance company to cover the treatment.
PSG	Polysomnography (a sleep study)
PCR	Provider Courtesy Review— You can request a provider courtesy review from an insurance company if a claim is denied due to lack of information. You would just provide the missing info and ask them to review it again.
TMJ	Temporomandibular Joint
UCR	An insurance term meaning “Usual, Customary & Reasonable” when determining insurance benefits— oftentimes insurance companies will use 80% of UCR to determine Out of Network benefits. This becomes the amount that an insurance company allows for a procedure. Use Fair Health, a website that can help you determine if your fees are UCR for your area (http://fairhealthconsumer.org/whoweare.php). This site includes Medical and Dental Codes, contains data for all 50 United States, and is updated twice a year.

ICD-10, CPT, Dental & HCPCS (DME) Codes

Holy cow there are tons of different codes!! I was having dreams I was drowning in codes, until I organized the different kinds into a neat and orderly chart, and now I can breath again. The only code not on the chart is the ICD-10 code (International Classification of Diseases). An ICD-10 code is a diagnostic code and is used in conjunction with CPT codes to bill medical insurance. **You will only be using one ICD-10 code to bill Oral Appliance Therapy, which is G47.33 (Obstructive Sleep Apnea).** As you educate yourself in medical billing, you may see another diagnostic code of 327.33, but that is an old ICD-9 code that is no longer being accepted as of October 1, 2015.

Codes for Billing



A CPT code is a “Common Procedural Terminology” code (commonly called a procedure code) and it is used to describe and bill evaluations, radiology, and other procedures. CPT codes must be used in conjunction with ICD-10 Codes (Diagnosis Codes), and they require documentation of what was done (such as a chart note). In my head I think of this like a simple math formula: What’s wrong (ICD-10 diagnosis code) + how you treated it (CPT code) = money in the mail. The other type of code you need to know is a HCPCS Code (Healthcare Common Procedure Coding System). These are a different kind of procedure code that is used specifically for DME (Durable Medical Equipment) stuff—like oral appliances. Even if you’re not a registered DME provider, you still bill the HCPCS code when billing for the appliance (along with the appropriate Diagnosis Code...see math problem above ;-D).

There are many, many different codes and each code has specific requirements that must be met in order to bill that code. In our office, we have streamlined everything into these few codes which I

Try to avoid using miscellaneous codes because they are red flags to insurance companies. Since miscellaneous codes don’t have a fee schedule, insurance companies highly scrutinize their use suspecting that doctors use those codes in order to gouge them.

have included in the table. I have also included some of the current UCR amounts (Usual, Customary & Reasonable), but check your areas UCRs on the Fair Health Website (<http://fairhealthconsumer.org/whoware.php>). The UCR listed *does not* mean that is what will be paid, it just means that these are typical charges.

Treatment	CPT Code	Dental Code	HCPSC Code	Current UCR Check Fair Health Website for your local amounts
<u>Exam/Consultation:</u>				
Sleep Initial Exam	99202 to 99204	D0140		\$125 to \$325
Comprehensive Exam	99215	D0150		\$125 to \$325
Re-Evaluation	99212 to 99214	D0170		\$125 to \$325
<u>Radiology:</u>				
Panoramic X-Ray	70355	D0330		\$110 to \$150
CT Scan for Sleep	70490	D0360		
		D0362		
		D0363		
Ceph	70350			\$110 to \$150
Tomogram (Unilateral)	76100			\$250 to \$275
Tomogram (Bilateral)	76102			\$325 to \$365
<u>Records:</u>				
Study Models	D0470	D0470		
<u>Adjustments:</u>				
Adjustment to Appliance	97762	D7882		
<u>Sleep Procedures:</u>				
Pulseoximetry	94762			
Appliance Reline	99212 & 97762 (3 units)			
Custom Fit Sleep Appliance (Individual Insurance)	E0486	D5999	E0486	\$3,250 to \$4,250
Custom Fit Sleep Appliance (Global Medicare)	E0486	D5999	E0486	\$3,500 to \$3,950
Temporary Appliance	E0485	D5999	E0485	
Home Sleep Test	95806			

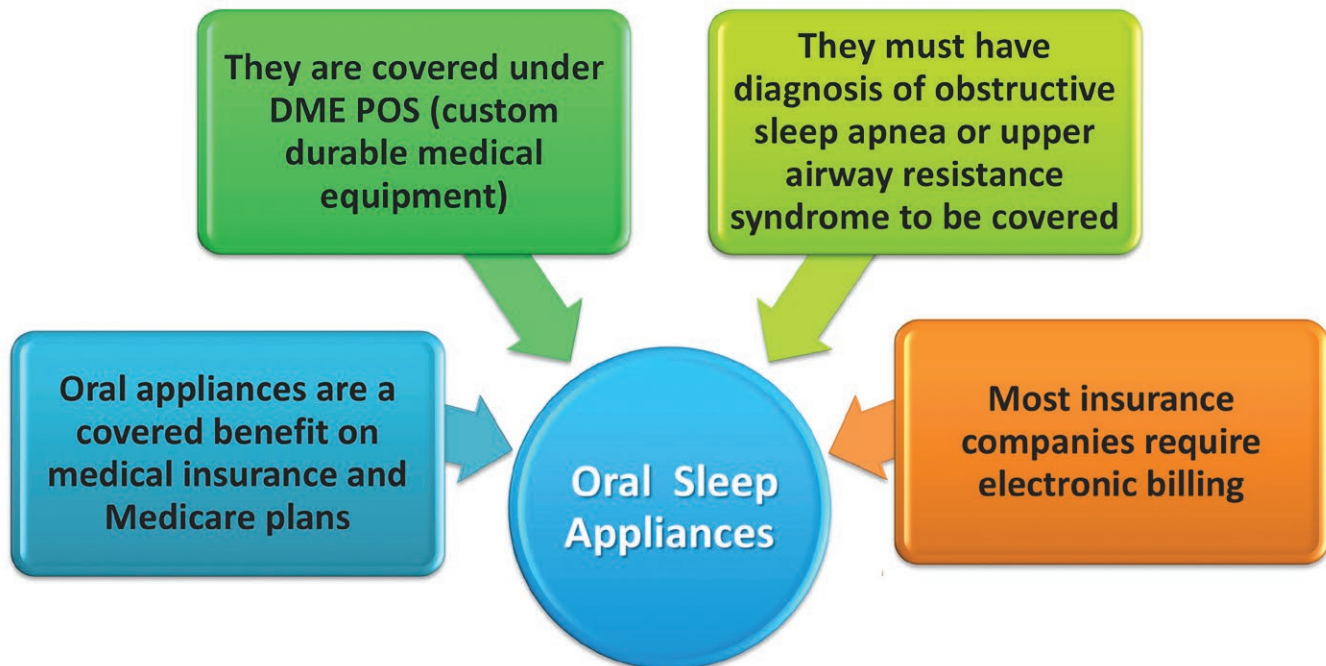
Which do I bill...Medical or Dental?

You may be at the top of your game in skill and experience with billing dental insurance, but billing medical insurance is a whole new world (you may wish to start singing Aladdin songs at this point)! Billing for sleep disorders may involve billing for just the appliance/orthotic/device as well as billing for the treatment and radiology associated with these procedures.

When considering whether to bill medically or dentally, keep in mind that OAT (Oral Appliance Therapy) for sleep is not usually covered by a dental policy, but is almost always covered by a medical policy. On the flip side, an oral appliance for bruxism (no diagnosis of sleep apnea, or only mild sleep apnea) is usually not covered by medical policies.

Medical Insurance Coverage

for Oral Appliance Therapy for Sleep Disordered Breathing



Dentists often have contracts with insurance companies as “dental providers”. You may bill appliances and treatment under your dental provider contract. If it is billed through the dental contract, in most cases the claim will be reviewed as out-of-network and out-of-network claims are paid at a lower percentage of benefit to the patient than in-network claims. A limited number of insurers will contract with dentists as medical providers. Many insurance companies will only contract medically with oral surgeons, and thus may refer to you as an “oral surgeon” in their contracts. However, when working with insurance companies for the purpose of doing OAT, it is becoming more common for insurers to contract with dentists as DME providers since this is the way Medicare works with dentists providing OAT, and most companies follow Medicare’s policies (another reason to be familiar with Medicare’s policies, even if you are not going to work with Medicare).

What's Your Variety of Insurance Company?

There are several types of insurance companies. As you begin to work with Medical insurance it is helpful to know a little bit about each kind, and the nuances between them....

Commercial Insurance — This is the most common type of insurance. These policies have in-network benefits and out-of-network benefits, have deductibles, have criteria that must be met in order for a procedure to go towards a deductible, and usually cover a percentage of the costs, leaving a portion for the patient to pay. Sometimes insurance cards from commercial insurance companies will say PPO (preferred provider organization) on them.

Medicare — This is a federal government run insurance for people over 65 **or** who have special circumstances (disabled, mentally handicapped, etc). Medicare usually pays for 80% of covered expenses (at their fee schedule), and there is usually a small yearly deductible that can change every year.

Medicare Supplement — Most Medicare patients have this plan in addition to Medicare to cover all or a portion of the 20% that Medicare doesn't cover. Supplement plans may have a separate deductible in addition to the Medicare deductible.

Medicare Replacement — An insurance plan for Medicare eligible people with low deductibles, and usually cover 80% of expenses after the deductible is met (just like Medicare). However these plans usually offer a wider array of covered benefits, and more access to doctors.

Medicaid — These plans are run by state governments for low income individuals and families, or individuals with disabilities. **Coverages and policies vary by state.**

How Medical Insurance Differs from Dental Insurance

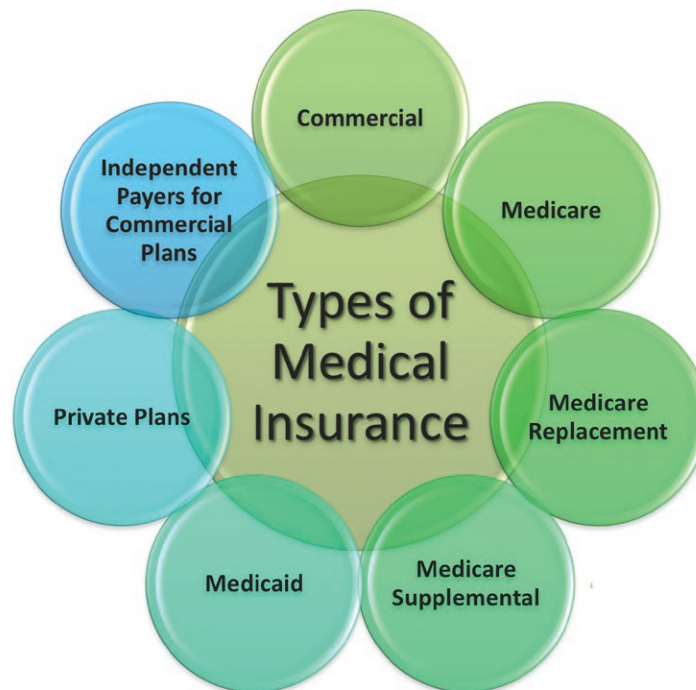
- 1 • Patient is not limited to small amount of coverage per year
- 2 • Covered benefit codes linked to specific diagnostic codes and specific clinical documentation
- 3 • Many more steps to payment

Private Plans — These are self-funded plans that companies use to insure their employees and provide their own coverage. Some of these plans are managed by the company itself, and some are managed by a third party. If a patient's insurance is a private plan it can have an "HMO" (health maintenance organization) on the card, but not always.

Independent Payors for Commercial Plans — Sometimes Commercial Insurance will contract out specific benefits or procedures to a third party management company. These third party companies are called Independent Payors.

DME POS — Durable Medical Equipment, Prosthetic Orthotic Services. This is not a separate type of insurance but it can be a rider on some insurance policies. Most insurance companies include this service coverage, but occasionally they will exclude it.

Types of Insurance You Will Encounter



Notes

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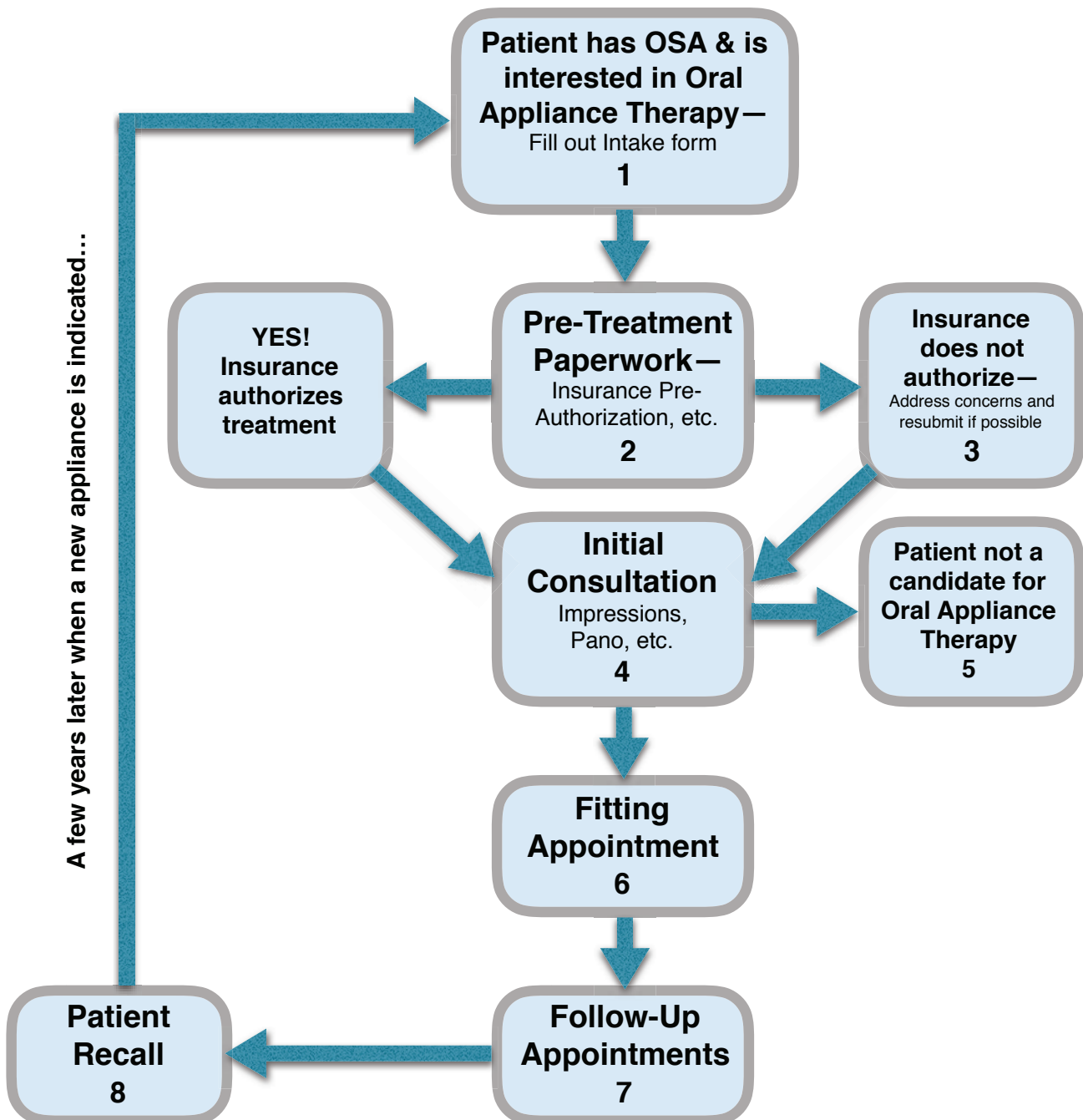
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Getting the Flow of It

Patient Flow Chart

Now that you've got your insurance foundation under your belt (and you know that DME POS isn't a harsh description of the quality of the DME ;-D) let's look at how an OAT patient flows through your office and how each step affects the insurance process. To help you visualize this, some steps have a number that corresponds to the following flow chart description. Enjoy!



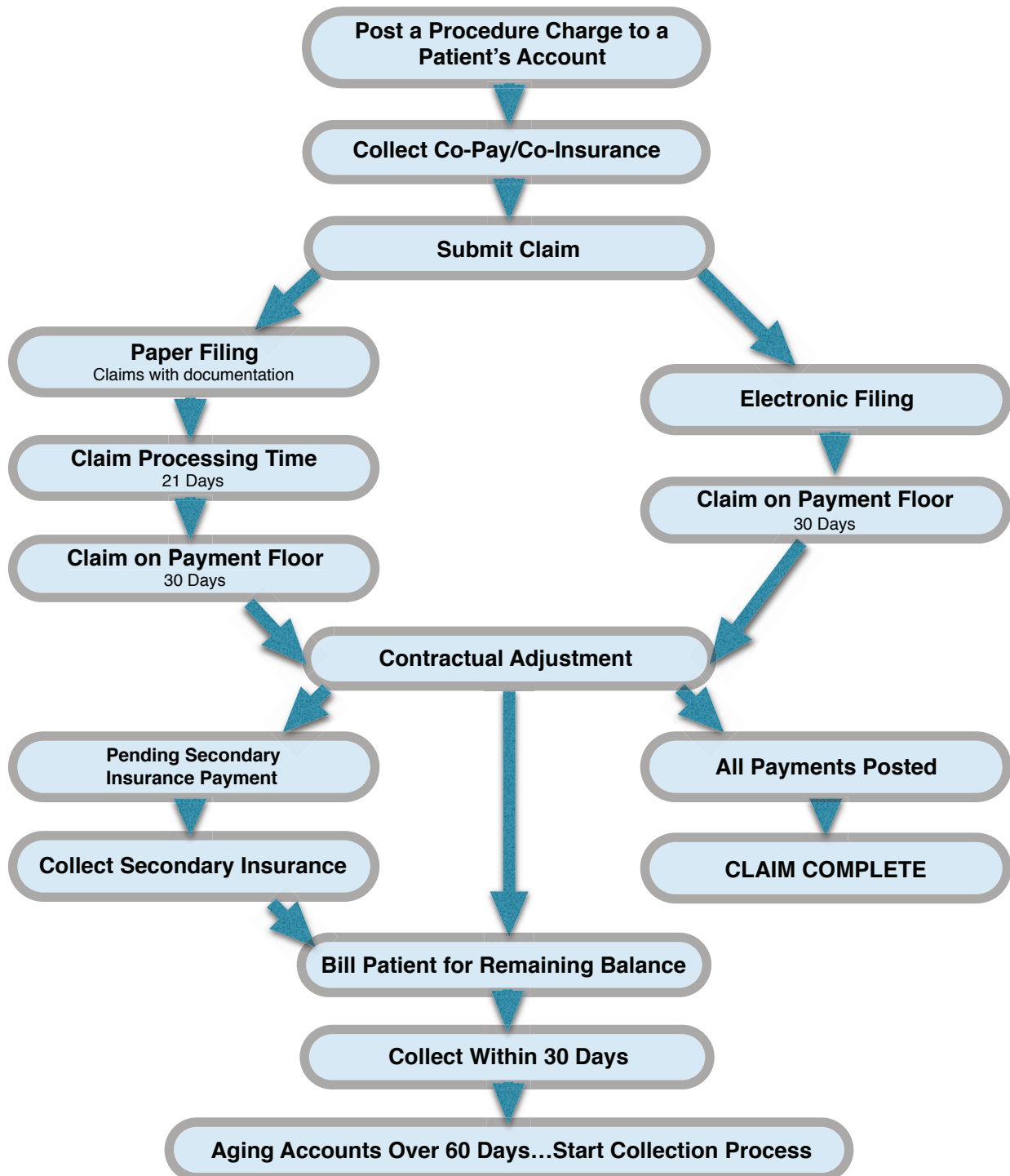
Flow Chart Steps

1. **Patient has OSA and is interested in Oral Appliance Therapy:** Collect needed patient information on intake form (see example in “Examples of Forms and Letters” at the end of this book). If this is your dental patient, some of this information you already have.
2. **Pre-Treatment Paperwork:**
 - **MD referral and PSG/HST Reports**—call patient’s sleep provider or family doctor and request a referral for the patient and a copy of their sleep study (polysomnograph). The referring provider can usually be any MD, PA or NP (not just a sleep doctor), unless the insurance company requires it to be a sleep doctor—we’ve only found one company that requires the referral from a sleep doctor...but it happens.
 - **Recent Pano**—If this is your dental patient check for a recent panoramic X-ray. If it is not your dental patient and the patient reports having had a recent pano, call their dentist and request a copy of it. If no recent pano is available, your dentist may choose to have one taken.
 - **Possible CT**—Your dentist may choose to have the patient get a cone beam CT before their initial exam to help with the evaluation, or they may prefer to refer the patient for a CBCT after their initial exam. In either case, these often need to be pre-authorized with the patient’s insurance (see *CT Authorization* later in this book). Keep in mind that the insurance company might require that the CT be ordered by an MD for it to be covered. Find that out when doing the Verification of Benefits. Also, MANY insurance companies consider all initial exams and records, including x-rays, to be part of the oral appliance therapy. In other words, you can do whatever you want as far as fancy records—but they won’t pay you any more than if you just did the appliance.
 - **Insurance pre-authorization**—Using the medical insurance info provided by the patient, contact their insurance company and request a pre-authorization for treatment of OSA using an oral appliance. You should know, prior to calling, whether you are in-network or out-of-network with the patient’s insurance company. Use the *verification sheet* to make sure all the important questions are asked. **Remember:**
 - Find out how the insurance company would like to be billed. Some insurance companies pay for a Global Period (one lump sum covering the exam, records, appliance and follow-up—Medicare is one of these), and some prefer certain codes when billing particular procedures,
 - Do you have any legal responsibilities (i.e. Medicare Patient, etc.),
 - Does the insurance company require an authorization and how do they require you to submit it (most companies have their own forms that can usually be downloaded from their website, keep a binder of current insurance company OAT policies and forms so you can start to be familiar with them),
 - If a pre-auth is not required, request a pre-determination of benefits (more on these later),
 - What paperwork does the company require to be submitted with the authorization (notes, referral etc.),
 - Does the insurance company require a letter of medical necessity, and if so, from whom? (the treating dentist or the referring provider?),
 - If a pre-authorization is questionable, then wait until the patient is seen in order to obtain additional documentation,
 - Appeal if your pre-authorization is denied—Is the denial something that you can overcome? Or do you need assistance from the ordering Dr.?
 - Complete the pre-authorization process, preferably prior to the patient being seen,

- When the patient's insurance company pre-authorizes treatment, call the patient and schedule their initial consultation.
3. **Insurance does not authorize treatment:** If the insurance company does not authorize treatment, investigate their concerns and address them in your re-submittal for pre-authorization, including any additional information if it will be helpful in obtaining a pre-authorization. If a pre-auth is not granted, call the patient and let them know their options (paying out of pocket, payment plan, etc.).
 4. **Initial Consultation:** You've made it to the initial consultation! After your dentist sees the patient there are several things she could have done that will need to be submitted to insurance to be paid for. Get a red HCFA form and fill it out (see example in "Examples of Forms and Letters" at the end of this book). Refer to the code chart for example codes. Here are some things to remember:
 - Make sure the treatment notes match the codes that you are going to bill for,
 - Be specific and accurate in your notes because they may be the ones you need to submit for authorization or payment,
 - Patient must sign consent forms—these are required by Medicare and most companies,
 - Diagnosis codes are subject to change, so make sure your claims go out with correct codes,
 - Fill out HCFA form correctly,
 - Send to the correct billing address for the Insurance co.—out of State Blue Cross/Blue Shield claims are almost always sent to your local office,
 - Appeal if your claim is denied—make your appeal short and to the point and use bullet points if needed.
 5. **Patient not a candidate for Oral Appliance Therapy:** This doesn't happen often, but if your dentist determines that the patient is not a candidate for Oral Appliance Therapy (due to lack of teeth or condition of teeth or whatever), write a letter to the referring provider letting them know the outcome of their patient's appointment.
 6. **Fitting Appointment:** Your patient has come back to be fit for their appliance. When they happily leave with their appliance you want to be paid! Grab a red HCFA form and fill it out (see example in "Examples of Forms and Letters" at the end of this book). Please refer to the List of Codes for commonly used codes. Make sure your patient signs a delivery form at this appointment - it's required by Medicare and most insurance companies (a copy of a delivery form is also at the end of this book). Also, make sure you code your appliance correctly on the claim form, CPT and ICD-10.
 7. **Follow-Up Appointments:** Every time the patient comes back for adjustments to their oral appliance, you will need to fill out another red HCFA form (unless the follow up appointments are included in the original fitting cost/payment "Global Period").
 8. **Patient Recall Appointments:** After the oral appliance is comfortable and has been determined to be in the optimal position (see Spencer Study Club for instructions on titration of oral appliances in the sleep lab) the patient is put on a recall for whatever period of time your dentist chooses, usually 6 months or a year. These recall follow up appointments are billed out with the same codes, depending on what is done at the appointment. Most patients' insurance will cover a new oral appliance after a few years (2-5 years, depending on the insurance). Keep a list of current insurance payouts for additional appliances and let your dentist know if the patient coming in for a recall appointment has insurance that will pay for a new appliance, so they can offer that to the patient. If they desire a new appliance, the process starts all over with a new pre-authorization.

Insurance Claim Flowchart

Just as a patient has a typical flow through your office, a medical insurance claim has a flow through the process of being paid, with many steps along the way. Some of these steps are the same as for a dental insurance claim, so this should be easy if you are familiar with dental billing. For my visual learners, here's a diagram of the path of progress towards payment.



Notes

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Perfecting the Pre-Authorization

Now before we get ahead of ourselves, and get into the fun of actually submitting the claims, we need to verify what insurance benefits our patients have and get any necessary pre-authorizations from their insurance companies. Oftentimes insurance companies require that before a patient gets a procedure or treatment, they get that treatment authorized by them or they will refuse to cover it. Basically they require you to ask “mother may I” before you proceed. This is called a pre-authorization (or “pre-auth” as the cool kids call it). After doing insurance for a while, you will learn which insurance companies require a pre-auth and which ones do not, but for now it’s a good idea to attempt to get pre-auths on every patient for imaging, CBCT Scans, and oral appliance therapy. In fact, in our office we call every patient’s insurance to request a pre-auth for those procedures, and if the insurance company says they don’t require one, we ask for a courtesy pre-determination. This way we, and the patient, are less likely to be surprised when something isn’t covered or isn’t covered at the rate hoped for.



When doing pre-authorizations, you will be faxing all your information to the insurance companies. To save yourself time in the future, keep a blank fax cover sheet on your computer ready to go. Fill in the Insurance company information and then save a copy of it under the insurance company’s name in a folder labeled Fax Cover Sheets. That way when the next patient comes in with that insurance company you can just pull out that fax cover sheet, verify the phone numbers on it, fill in the patient’s info and print it.

Pre-authorizations and pre-determinations (“pre-d’s”) are a wonderfully useful tool in verifying what the insurance company’s benefits are and they make it much easier to clearly explain to a patient what their insurance covers. However (and this is important!), ***pre-authorizations and pre-determinations are never a guarantee of payment.*** Really? Yes! I was floored when I learned this! So to eliminate any bad feelings towards our office we make this very clear to the patient, explaining that we are on their side, and will do everything we can to get their insurance to help them, but there are no guarantees and we are just presenting them with the information that ***their*** insurance company provided to us.

If your office does **paper charting**, keep the fax cover letter and pre-auth form in their chart so that you can resend information easily if the insurance company doesn’t get the complete fax or something weird happens. If your office does **electronic charting**, scan the entire pre-authorization packet into the patient’s chart so that you can pull it up quickly and resend it to the insurance company, if they request it. This also gives you a record of when you sent the pre-authorization.

As a side note, when a pre-authorization is not required by an insurance company, pre-determinations will probably not be offered by them either unless you ask and are specific. Getting a pre-determination also lets you know that your patient's case was reviewed and that it met their plan guidelines. Although they don't guarantee payment, pre-determinations can be very helpful when fighting an appeal, so make sure you always ask for them. We have won many appeals using pre-d's when the pre-auth wasn't required.

Verifying a Patient's Insurance Benefits

Here is where all the magic begins. Getting this right gets everyone off on the right foot together—you, your patient, and their insurance company! Being accurate when verifying benefits allows you to be accurate with your patients and everyone wins! Grab yourself a "Patient Verification of Benefits" form (included at the end of this book) and follow these steps:

1. Fill in the patient's name, birthday and insurance information from the OAT Patient Intake Form (also included at the end of this book), including the insurance company's phone number.
2. If you are working with an out of state policy or one that you are not familiar with, obtain a copy of their medical guidelines for their OSA policy and keep it handy. They are all so different and vary widely state to state (and even policy to policy sometimes). These can be found on the insurance company's website or by googling the patient's plan guidelines for OSA. If you can't find them, ask a representative and they will direct you to it.

RoseMary always says that "Talking to insurance reps is like talking to a teenager—if you don't ask specific questions, you won't get specific answers." I think they might have special training in being "vague". Try to be very clear in your questions when talking to them, and that will help you get clearer answers.

Unitedhealthcare Procedure Policy

Non-surgical oral appliances, worn during sleep, are intended to treat OSA by keeping the airway open in one of three ways: by pushing the lower jaw forward (a mandibular advancement device or MAD), by preventing the tongue from falling back over the airway (a tongue-retaining device) or by combining both mechanisms (ASAA, 2007).

Oral appliances are recommended for treating OSA in ANY of the following circumstances:

- Mild OSA AND patient is unable to tolerate positive airway pressure (PAP) therapy OR refuses PAP
- Moderate to severe OSA as a component of treatment that includes additional modalities such as PAP therapy with reduced pressure
- As a standalone treatment for moderate to severe OSA, if patient is unable to tolerate PAP therapy OR refuses PAP, although this may not be the most effective therapy.

Non-Surgical Treatment of Obstructive Sleep Apnea: Medical Policy (Effective 07/01/2011)

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3. Some insurance companies require you to verify benefits online before you speak to a representative. Check the insurance company's site to verify benefits first if necessary. Some of the information you need will be available through this online access. You will still need to call them afterwards to request a few of the following things.
4. Call the insurance company and tell them you are a doctor's office calling to verify benefits for your patient and give them the information on the form.
5. Write down the insurance rep's name, the time you started talking to them and ask for a reference number for the call (they probably won't give this to you unless you ask, but it will be extremely helpful to you in future calls if you can give them a reference number for a previous call. Also, if you write down the time, the insurance company can pull the recording of your call and verify what was said).
6. Mark whether you are in-network or out-of-network with this insurance company and ***make sure the rep you are talking to knows if you are in-network or not so they can give you the right information.*** If you are out-of-network, find out if there are any in-network providers within 26 miles of you. If there aren't any that close to your office, you can request a **Gap Exception** and the insurance company will give you in-network benefits as an out-of-network provider. These are becoming less common, since dentists are increasingly becoming in-network with medical insurance companies.
7. Give the rep the code you are verifying, which is usually the E0486 code (oral appliance) and they will tell you a percentage that they will cover.
8. Ask if a pre-authorization is required for coverage and mark the appropriate box.
9. If a pre-authorization is required, ask
 - "Do you have your own form that you'd like me to use? And if so, where can I find it on your website?" Mark that down.
 - "What are the criteria for coverage?" Whatever they tell you, take detailed notes. They might tell you the patient needs certain co-morbidities (other things wrong, like high blood pressure or a mood disorder), or they need to try CPAP for a few months, or they need to have a certain apnea-hypnea-index (AHI) etc. This will be important to know when doing the Oral Appliance pre-authorization.

When talking to insurance companies ***always, ALWAYS*** ask them for the reference number for your call. This allows you to refer back to the phone call when speaking to the next insurance representative. We have won many appeals when we've been able to reference a conversation and the Insurance Rep "dropped the Ball" so to speak. Having reference numbers for all your insurance company conversations is like having an insurance policy for your claims!

If you are out-of-network with an insurance company, make sure you verify and verify and verify with the insurance rep that they are quoting the out-of-network benefits. If the benefits they are quoting seem high, they are probably quoting you in-network benefits. There are few things worse than quoting a patient in-network benefits when you are actually out-of-network!

* Note: A few policies are written to cover RDI (Respiratory Disturbance Index) instead of AHI, or they may require AHI & RERAs (Respiratory Effort Related Arousals), or RDI. Make sure you know how your patient's policy is written so you can submit the correct information.*

- “What fax number do I need to send the Pre-Auth to?” and “What number should I call with questions about the pre-auth?” (You're getting the hang of this...write those down ;-D)
10. If a pre-authorization is not required, ask if they will do a courtesy pre-determination for that code. This just helps when talking to patients, allowing you to let them know what their insurance “MIGHT” cover. Pre-auth's and pre-d's are NEVER a guarantee of payment. As I mentioned before, having a pre-determination can also be extra ammunition if you are appealing a denied claim.
 11. Now let's fill in the box. You will see a lot of lines like this ____/____. The first portion of that line is for you to write down information you find out about the patient's Individual deductible or out of pocket (OOP) Max, and the second part of the line is for the Family deductible & OOP Max.
 12. Ask the rep what the patient's Individual and Family Deductibles are.
 13. Ask them how much of their deductibles they have paid already this year.
 14. Ask them how much of their deductibles they have left to pay in order to meet their deductibles.
 15. Ask them what their Individual and family OOPs are (Out of Pocket Maximums), and how much of those the patient has met.
 16. If the patient has met their OOP expenses, ask at what percentage the insurance company will pay.

Interpreting Eligibility & Benefit Information

5/9/15 LT Out: \$5000 ded, \$0 met, then 50-50, oop max \$4000 (ded does not go to oop max). In: \$2500 ded, \$2049.82 met, then 80-20, oop max \$2000 (ded does not go to oop max) No pre auth required, no gap on front end, patient can request it after claim has been paid.

5/9/15 LT Out of network: \$2000 ded, \$0 met, then 50-50, oop max \$6000, ded does not go to oop max. no pre auth, no gap due in network providers available (In: \$1000 ded, \$0 met, then 80-20, oop max \$2000 ded does not go to oop max)

5/9/15 LT In: \$600 ded has been met, 80-20, oop max \$2000, \$1225.03 met. Out: \$850 ded, \$600 met, then 50-50. oop max \$3000, \$1225.03 met. Pre auth is required. Pre auth and Gap must be requested by patient or in network provider.

17. Ask if the patient's policy has a DME benefit Maximum. Oftentimes an insurance company will only pay a certain amount for DME, so even if they have coverage and met their deductible the insurance company won't cover it because they have met their DME Max for the year (kind of like dental insurance maximums). Find out if the patient has met their DME max, and then ask if the policy's DME max is a yearly benchmark or a lifetime benchmark. If it is a lifetime maximum, no further DME claims will be paid... thankfully, lifetime maxes are pretty rare.
18. Find out if the policy is a calendar year plan (starts January 1st and ends December 31st). If it is not a calendar year plan, write down when the plan starts and ends.
19. Using all this information you should be able to figure out how much the patient's total anticipated OOP should be. Write that in the spot provided.
20. If you find out anything weird, different or interesting about the policy or benefits write that in the notes provided, date it and put your initials at the bottom so all the staff know who verified the benefits for this patient.
21. In our office, we take this form into the patient at the end of their initial exam so we can clearly go over what we've found out and discuss any required criteria the insurance company has and the patient's financial picture going forward. We then give a copy to the patient to help them do their own investigating if they'd like.

If you don't have a hands free phone headset yet, ask your doc to spring for one... **immediately.**

In case you haven't noticed, you're going to be on the phone, and on hold, a lot.

Awesome!



Medical Chart Notes

A word about your chart notes. You, your doctor, and your fellow staff are probably not familiar with doing medical chart notes—they are way more detailed than dental notes. This is critical for your whole office to understand and be on board with for several reasons:

1. Medical Insurance companies and Medicare require several things to appear in your notes in order for your patients' claims to be accepted and processed.
2. When you're audited (it's not a matter of *if*, it is only a matter of *when*!) you will need to provide as much documentation as possible to support your treatment plan.
3. Keeping complete, accurate, and detailed chart notes limits an insurance company's ability to interpret them incorrectly and deny your claims, and on the flip side it makes appealing a denied claim way easier. The better your notes, the fewer denials you will get.

4. Good chart notes make a good impression on insurance companies and other medical doctors (most medical doctors think dentists don't know how to take good chart notes, so your office will seem more reputable to medical doctors when they see your awesome notes!).

In our office, Dr. Spencer has always, *always* insisted that our chart notes be as good as, or better than any physicians' notes we see. We want to be the gold standard of chart notes! (See Spencer Study Club for an in depth description of how we do chart notes)

Getting Paid for Imaging

[First off, remember that for many insurance companies E0486 is all inclusive of everything you do, including any records, x-rays, scans, you name it...they consider it included as part of the oral appliance therapy. In other words, you can take all the records and fancy scans that you want...they just won't pay you any more. The information below is for when this is NOT the case.]

If your office has a Cone Beam CT machine, or access to one, and your doctor has ordered a CBCT for a patient, most insurance companies require a pre-authorization. Some require that CTs be ordered by an MD...and they mean a medical CT, not a CBCT. Before you make the call to pre-authorize a CBCT, make sure that you have the chart; they will ask questions like symptoms, duration, accident history, etc. You will also need to have the insurance information handy. Don't forget to ask the insurance company if they require the MD to order the CT (in which case it may need to be done in a hospital or private imaging clinic).

1. When calling an insurance company for an authorization you will first talk to an Intake Specialist who will ask you a few questions such as:
 - Patient name, Date of birth
 - CT or MRI body part (in our case it will be facial)
 - Diagnosis
 - Onset of symptoms and duration
 - Some will need the CPT code for the procedure requested
2. Ask the insurance rep if they can give you an effective date range for the authorization, in case the patient has to reschedule. If they only give you a few days and something happens to make the patient unable to make their appointment, you may have to call for another authorization (this is true for OAT too...not just imaging).
3. If the intake specialist is not able to authorize it at their level they may forward you on to a nurse reviewer; he/she will ask the same questions but will ask for more detail. It is important to give thorough information for each question. The more information you provide, the better the chance of having the CT authorized at this level, and of avoiding a peer to peer physician review. If information meets the criteria, he/she can give you an immediate decision and an authorization number.
4. If the information is not sufficient or the criteria are not met, the nurse will send it over for peer to peer physician review. Normally, when this happens the physician reviewer will call back to talk to your doctor within 24 hours.

5. Once you have an authorization number you can enter that on the referral sheet that is being faxed to the imaging center. (By the way, do a little research to find out what imaging center you want to refer your patients too, and request a referral pad from them—that will be the referral sheet that you put the authorization number on, and fax to them.)

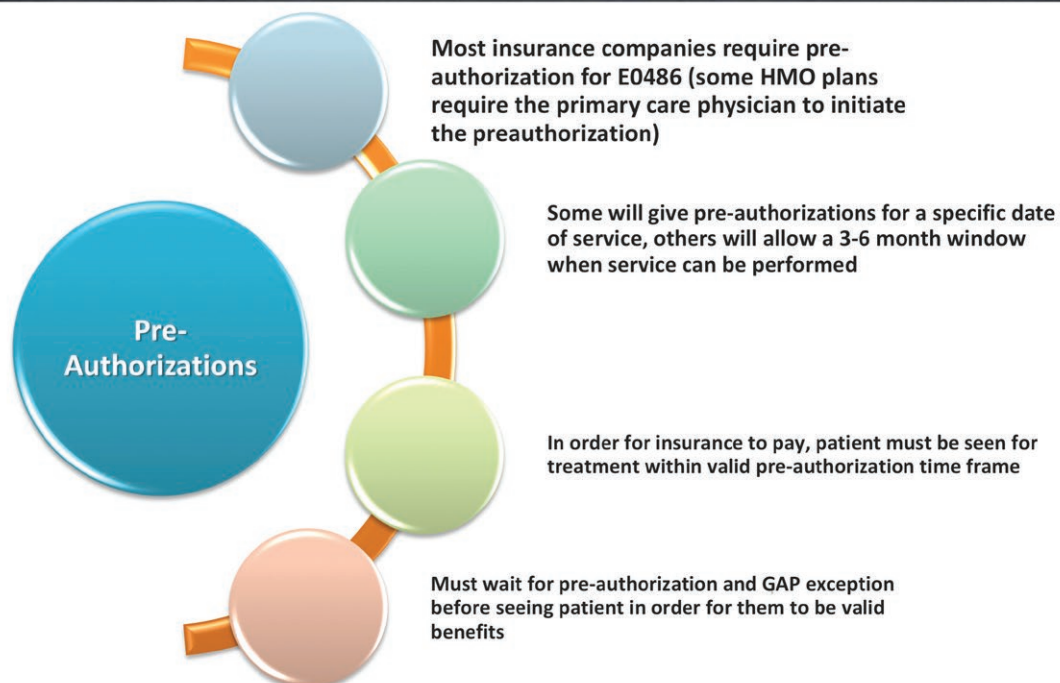
Here are some examples of wording you can use with insurance companies for different diagnostic x-rays...

CT — This CT is necessary to evaluate the airway to rule out possible obstructions, lesions/tumors, examine the tongue position, look at facial bones and jaw bones for any fractures and to measure the width of the airway. Evaluation of these structures prior to treatment with an oral appliance for diagnosis of obstruction sleep apnea is critical to determine if the patient is a good candidate for oral appliance therapy.

Note: *Medicare will not cover CT's — so when offered to a Medicare patient they need to know that Medicare will not cover it and they will need to sign an ABN if you wish to charge them for it.*

Some insurance companies allow you to capture a pano, cephalogram and tomogram from a CBCT and bill out for those 3 x-rays instead of billing for a CBCT. This is useful, especially if the insurance carrier does not cover CBCT's but your doctor still feels it is the best diagnostic tool to use. For instance, Medicare does not currently cover CBCTs, so you could break up the CBCT and bill it as the 3 separate x-rays (and of course review the entire volume as well as the 3 separate x-rays). You will be reimbursed way less than if they covered the full CBCT, but at least you could get something. This is another way to bill your CBCT if the insurance company only covers CTs ordered by an MD. Regardless of coverage, we always have our CBCT read by a medical radiologist (you may use a dental radiologist if you prefer) and a report is provided. They will look for things, like sinus issues, that we are not as expert in.

Pre-Authorizations



PANO (70350) — Looking at teeth and periodontal tissues for cavities, abscess, bone loss

CEPHALOGRAPH (70355) — Looking at the airway for possible obstructions and tongue position

TOMOGRAM (76100 & 76102) — Looking at jaw bones for any fractures or lesions

Oral Appliance Pre-Authorization

Pre-authorizations are so important that I feel a step by step run-through would be very helpful to any newbie to medical insurance. We usually do our pre-auths before the patient is seen for the initial exam, unless we have to wait because the patient's insurance carrier requires additional information such as dental findings (sufficient dentition etc.), requiring us to wait until after the initial exam to request a pre-auth. So whether you are doing this before you see the patient or not, the format is the same. Let's strike our insurance billing super hero pose and get started!

Here is your step by step process:

1. Check your Verification of Benefits to see if the insurance company requires you to use their pre-auth form. If not, I

have provided a generic form at the end of this book. If they do, you will need to go to the insurance company's website, log in (which will require you setting up an online account with them if you haven't done this previously), locate the forms section of their website and print out the pre-authorization form.

2. Fill out the required information.

3. Assemble all the required forms which could include:

- **Forms from the Referring Physician:**

- Copy of sleep study
- Copy of referral
- Copy of chart notes
- Letter of Medical Necessity (if required by the Insurance company)
- DWO (Detailed Written Order) - this is from the referring physician as well, and contains the patient's name, MD's name, MD's legible signature, MD's NPI number and the date signed by the MD, and a detailed description of the therapy, devices etc. recommended by the MD

Shameless plug for the "Spencer Study Club." The Epworth Sleepiness Scale is not as good of a screening tool for women, as women more often described being "fatigued" rather than sleepy or falling asleep. In the Spencer Study Club Jamison talks about how to make this tool more effective, since nearly all insurance companies request the information from the scale.



- **Forms from Your Doctor:**

- If you have seen the patient for an initial evaluation already, include your doctor's notes and intake forms

4. Fill out the fax cover sheet. Make sure you write in the patient's name, DOB and ID# and fax it with all the supporting documentation to the pre-auth department fax number on your Verification of Benefits form.
5. Record when you sent off the pre-auth (possible tracking spreadsheets are suggested in the Spreadsheet section of this book), so you can follow up with the insurance company in a few days.
6. Once the insurance company receives your pre-auth it could take up to 2 weeks to receive the approval. However, most companies will get you an approval (or request more information) within a few days.
7. When you receive the pre-authorization, note that in your tracker and call to schedule the patient.

A Few Tips About Pre-Auths....

In our experience, insurance companies in general have been very good at covering oral appliances on the condition that *the patient meets their criteria for treatment of sleep apnea*. These criteria are slightly different for individual carriers but most companies follow the Medicare Guidelines for your jurisdiction. (See your area's Medicare LCD for this info.) Most insurance companies require a patient to have an AHI of at least 5 in order to cover therapy, and some companies won't cover a patient with an AHI of 5-15 unless they have documented co-morbidities such as high blood pressure, cognitive mood disorders or excessive daytime sleepiness (measured by an Epworth Sleepiness Scale score higher than 10). We have found it very helpful to have some of the criteria and co-morbidities listed on our Verification of Benefits form to help us when talking to insurance companies. Some possible criteria to include on your form are:

- Excessive daytime sleepiness (documented by either Epworth greater than 10, or a Multiple Sleep Latency Test [MSLT] greater than 6); or
- Documented symptoms of impaired cognition, mood disorders, or insomnia; or
- Documented hypertension (systolic blood pressure greater than 140mmHg/diastolic blood pressure greater than 90mmHg); or
- Documented Ischemic heart disease; or
- Documented history of stroke; or
- Greater than 20 episodes of oxygen desaturation less than 85% during a full night sleep study, or any one episode of oxygen desaturation less than 70%.

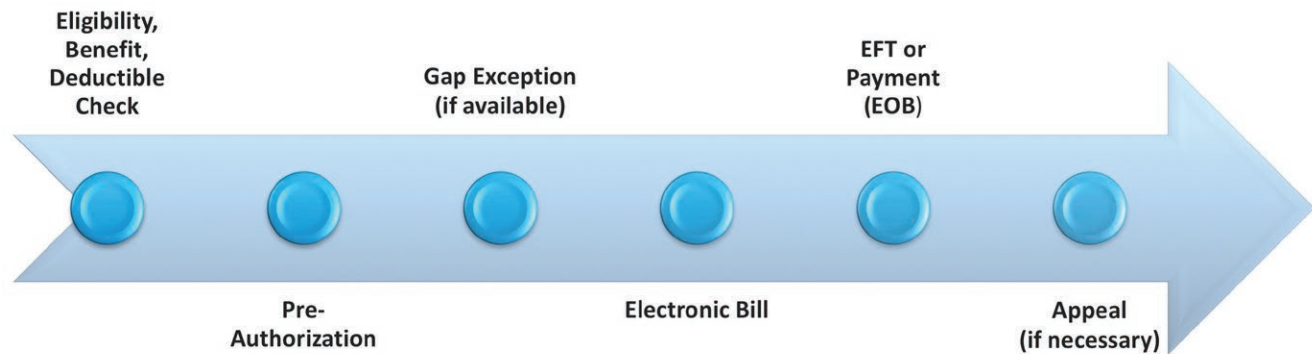
As you download pre-auth forms from insurance websites, print a blank one and fill out all the information that is redundant (your address, TIN numbers, Doctors' names, contact names, etc). Keep this in a notebook so that you can just make copies of them as new patients come along and you won't have to download the form every time. We call this "the Insurance Bible" and it's a wonderful time saver!

It would be very helpful for you to understand a little bit about sleep studies when you are dealing with insurance companies. If you are not familiar with them, I have included a few instructional handouts Jamison created (when working with doctors) in an appendix at the end of this book. Just a little light reading for later!

The more co-morbidities a patient has (and is able to document), the more likely their claim will be covered. If you are looking for co-morbidities always check the medication list and familiarize yourself with common heart, blood pressure and psychological medications. Your chart note may have no mention of HBP (high blood pressure) because they were in for a sleep condition and the patient didn't think to include it, but they did list all the meds they are taking. Google is the easiest way to find this, but be cautious because some meds are used for many conditions. You can always ask the patient or the referring physician for more chart notes.

Some companies require that a pre-authorization be submitted with a letter of medical necessity which establishes that the patient has tried CPAP and is intolerant. Put this information on your Verification of Benefits form as well.

Steps for Getting Paid



Notes

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Submitting a Claim

Now that you've done all the prep work, the hard work is done! Most of you have submitted dental claims, and will know how to do this. HCFA forms are similar to Dental Claim forms. If you are truly a newbie at this, here are some basic directions to submit a claim.

1. Fill out the HCFA form using your software or by filling out the form by hand. I have provided a mock HCFA form in the "Examples of Forms and Letters" section at the end of this book as a template for you to look at if you are filling it out by hand.
2. Write the insurance company and their address on the top right side of the form, in the empty space.
3. Mark what kind of insurance company you are submitting this claim to in the box labeled "1", and the Insured's ID number in "1a".
4. Fill in the patient's and insured's information in boxes "2-13".
5. In "14-24" fill in the referring provider info, Diagnosis info, and Prior Authorization number if you have one, as well as the Dates of Service and CPT codes in the spaces provided.
6. In "25-33a" fill in your doctors info and total charges.
7. In general most insurance companies will need the following information with the claim form as well:
 - Chart notes of face-to-face examination of patient by treating physician (not your dentist, but the referring MD)
 - Diagnostic sleep study dated within the last 5 years
 - Written order from treating MD for oral appliance therapy
 - Dentist's clinical examination notes
 - FDA 510(k) approval of oral appliance
 - Proof of delivery of oral appliance to patient
8. Mail the form and documentation to the insurance company's claims address.

You cannot waive co-pays or deductibles for your patient...the office of the Inspector General will view that as a kick back or insurance fraud because the patient is always responsible for the difference between billed charges and policy allowed amounts. Check your patient's EOB's, anything listed as patient portion is truly patient portion. Although you can't consistently write off patient portions without eventually getting into trouble for fraud, you can do a write off for true financial hardship—just make sure you document the hardship in the patient's chart. If you have patients without insurance, discounts are permissible and even encouraged by the Inspector General.

Notes

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Appealing a Denied Claim

“Gosh darn it! My claim was denied! I suck as an insurance biller, am a bad human, and can’t dance either!”

Relax! Denials happen to everyone, especially in the insurance world. You are a great person, and probably a wonderful dancer :-). I have provided an appeal letter in the “Examples of Forms and Letters” section at the end of this book so you can have a template to follow when submitting your appeal. Here are some useful tips to use or keep in mind when you appeal the insurance company’s decision:

1. Appeal directly to the reason that is cited in the denial: medical necessity, coding, etc.
2. Identify the address where you will need to mail your letter of appeal. The appeals’ address may be different than the address for the initial claim submission.
3. When writing your appeal letter, indicate:
 - the date
 - claim number
 - date of service
 - your member identification (subscriber) number
 - patient’s group or policy number
 - amount of the charge
 - medical provider’s name
 - a detailed description of the denial (why you are writing, and what you are requesting—appeal letters *must* be clear and concise).
4. Include any supporting documentation with your appeal letter, such as letters of medical necessity from your doctor and/or the prescribing physician, and medical records (including progress notes, radiology records, etc.).
5. Cite the standard that you used in providing the care, and that the care was routine and standard for _____ diagnosis.
6. **Appeal Twice- 70% of appeals are denied the first time.** Most denials require two appeals for 2 reasons: first, insurance carriers do not always provide credentialed professionals for the initial review; and second, insurance carriers often provide details in the Level I appeal response which may require further discussion. Level I appeal responses should be scrutinized for legal and contractual compliance. Some of the potential questions you should ask include:



- Has the insurer provided the internal rules, guidelines or review criteria applicable to the denial? If not, is the carrier in compliance with potentially applicable denial disclosure laws?
- If provided, do the internal rules, guidelines or review criteria cited by the insurance carrier actually apply to the treatment in question? Do the internal rules, guidelines or review criteria conflict with your internal quality care standards?
- Has the insurer provided review by a credentialed professional familiar with the type of treatment and has that credentialed reviewer suggested appropriate alternative care which has equal likelihood of efficacy?
- If the appeal involves a question of medical coding, has the insurer provided review by a licensed coder familiar with the type of treatment?

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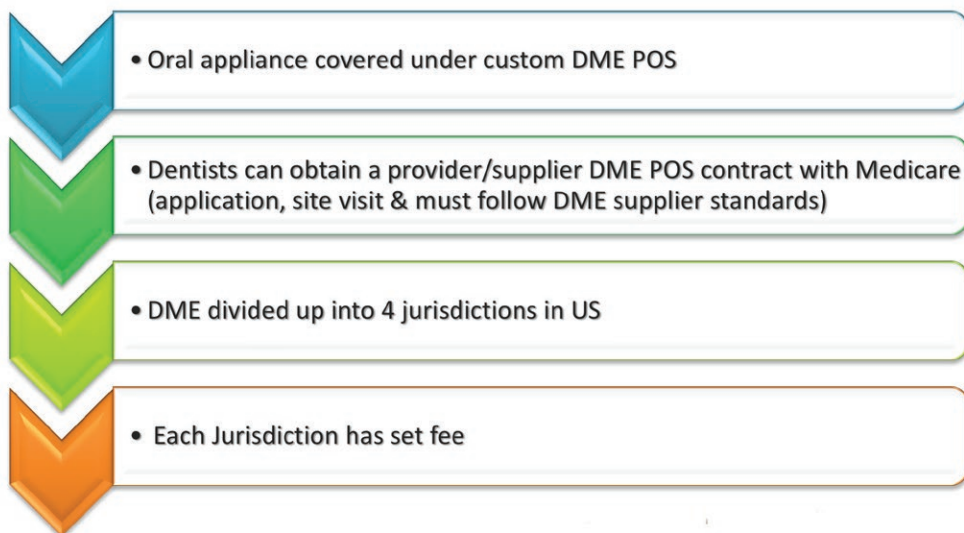
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Medicare Basics

Welcome to the Wacky World of Medicare! This is a complicated world, but one that is well worth learning in order to provide the best care for your patients and help the most people get the help they need with an oral appliance. There is a LOT of technical information in this section. If you find your eyes glazing over when reading this section, try taking notes to keep you focused. Or, if you're too far gone, take a break and stand up, do some jumping jacks to clear your head, and then come back to it. You can do this! It will be worth it! We'll start with some basics...

It's a really smart idea to hold every sleep patient to Medicare standards as most insurance companies follow the Medicare guidelines.

Medicare

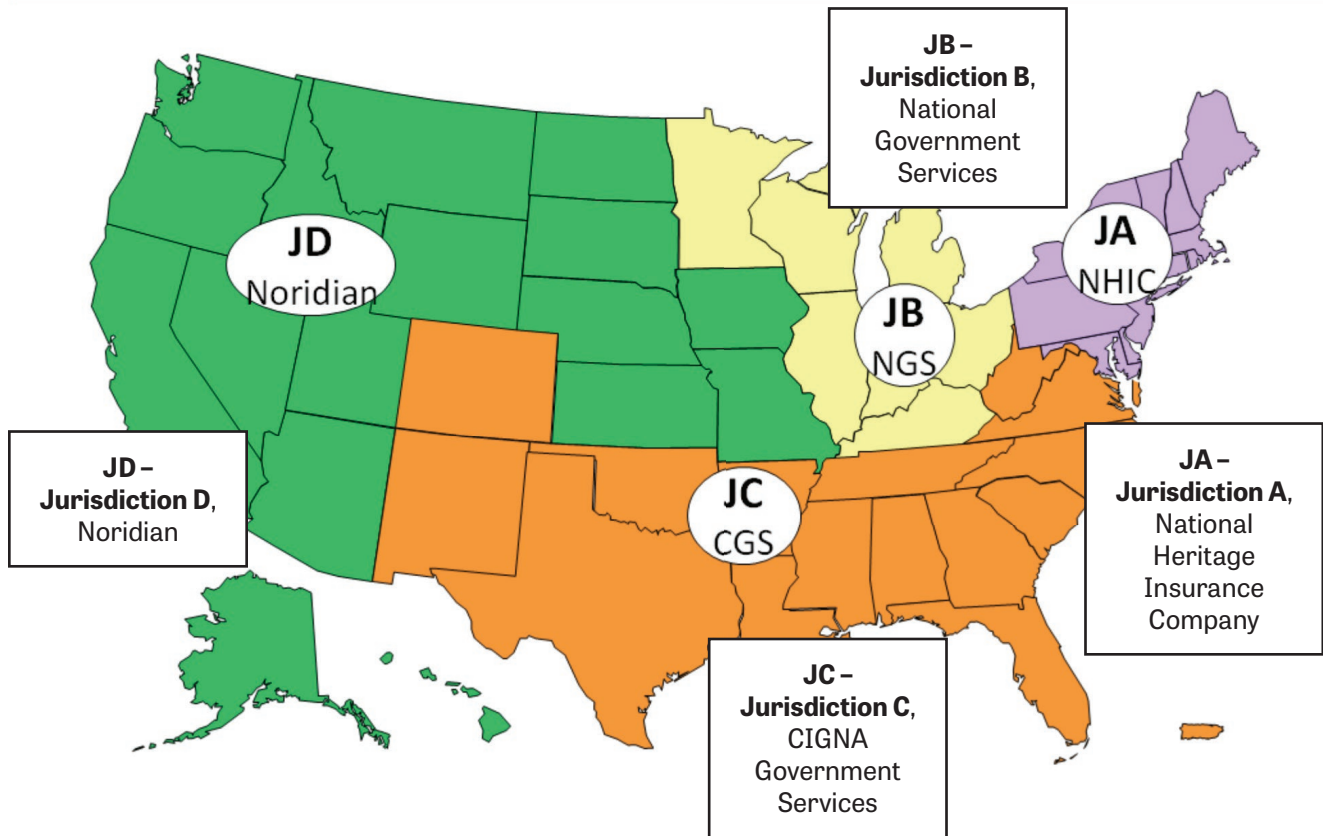


Medicare Jurisdictions (Regions)

Medicare is the umbrella, and under the umbrella are huddled 4 little jurisdictions, each managed by a different company. Here is a current map of the jurisdictions and management companies. These management companies can change when their contracts are up. MAC stands for Medicare Administrative Contractor.

DME MAC Current Jurisdictions

as of August 2015



Medicare Basics

Medicare has 5 basic components: Parts A through D and DME.

1. **Part A** has no premium for all Medicare eligible persons and covers **hospital** bills (we don't ever bill under Part A).
2. **Part B** is for physician's services, etc. and has a monthly premium. When your doctor bills for Oral Appliance Therapy, only adjustment appointments after the 90 day global billing period are billed under Part B.
3. **Medicare Part C** is the designation for all private policy Medicare Advantage plans. They are not part of Medicare, but they must provide the "equivalent" care of regular Medicare. Be aware that Medicare Part C plans have rules and coverage that can vary greatly.
4. **Medicare Part D** you might already be familiar with and it has to do with prescription drugs.

There are 2 cool advantages to working with Medicare:

1. There are no pre-authorizations required, and
2. Medicare will pay interest on the claim if it is not paid within 15 days.

5. **Medicare DME POS** is for durable medical equipment, prosthetics, orthotics & supplies. Oral Appliance Therapy is covered under DME POS and is paid as a global fee for everything you can do for the patient within 90 days (including the appliance and adjustments).

Medicare Part B and Dentists

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Palmetto GBA Home / Jurisdiction 1 Part B / Articles / General / HCPCS Codes E0485 to E0486: Oral...

Medicare claims related to the fitting, initial/subsequent adjustments and repairs of an oral device should be submitted to the appropriate DME MAC and not as evaluation and management (E/M) services to the A/B MAC. Additionally, any radiological or other services performed in order to guide the adjustments of the oral device should not be submitted separately to the A/B MAC, as the Medicare payment associated with HCPCS codes E0485 and E0486 already includes any required adjustments to ensure a properly fitted device.

After considerable internal study and with agreement by dental experts at the CMS central office, Palmetto GBA has confirmed that all services related to the codes - including initial patient evaluation, any required imaging, all fitting and post fabrication adjustments - are contained in the codes and payable only by the DME MAC.

fitting and post fabrication adjustments - are contained in the codes and payable only by the DME MAC.

Medical Policies
Online Provider Services
Publications
Resources last updated on 01/11/2010

PDAC Medicare Pricing, Data Analysis and Coding

NORIDIAN
Administrative Services LLC

PDAC
Medicare Pricing, Data Analysis and Coding

Mission Statement: Pricing, Data Analysis and Coding (PDAC) contractor is committed to quality and accurate results, within time frames that exceed our customers' expectations and is of great value to CMS.

DMECS HCPCS Review NDC/HCPCS Crosswalk OACD Resources

Home / Resources / Advisory Articles / E0486 - Custom Fabricated Oral Appliance for OSA - Coding and Utilization Guidelines

E0486 - CUSTOM FABRICATED ORAL APPLIANCE FOR OSA - [Advisory Articles](#)

Effective for claims submitted on or after September 1, 2011, the only products that may be billed using code E0486 are those that have undergone Coding Verification Review by the Pricing, Data Analysis, and Coding (PDAC) Contractor and that are listed on DMECS in the Product Classification List which is located on the PDAC website,
<https://www.dmepdac.com/dmecsapp/do/search>

Effective for claims submitted on or after September 1, 2011, the only products that may be billed using code E0486 are those that have undergone Coding Verification Review by the Pricing, Data Analysis, and Coding (PDAC) Contractor and that are listed on DMECS in the Product Classification List which is located on the PDAC website,
<https://www.dmepdac.com/dmecsapp/do/search>

Questions concerning the coding of these products should be referred to the PDAC, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: <https://www.dmepdac.com/>. For additional information about coverage, refer to the Oral Appliances for the Treatment of Obstructive Sleep Apnea LCD and policy Article.

Date Posted 05/23/11

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Dentists can have 2 contracts with Medicare, with regard to oral appliance therapy:

1. DME POS contract in order to bill the Global Medicare fee for the appliance and 90 days of treatment, and
2. A contract for Medicare Part B to bill out oral appliance adjustments after the 90 days, as well as services for TMD evaluation and management (if you do that sort of thing).

If you choose to take Medicare patients and “contract” with **Medicare Part B** in order to bill follow-up visits you will be considered, and enrolled, as a **Participating Provider** and you will agree to **Accept Assignment** (more on this in a minute).

As stated before, Medicare DME pays a “global fee” which includes the appliance and 90 days of follow-up and treatment. There are 3 standards that must be met for Medicare DME to cover an appliance:

1. Oral Appliance Therapy must be provided and billed by a licensed dentist
2. **The appliance that is used must be a PDAC (Pricing, Data Analysis & Coding) approved appliance**, (for a current list of PDAC approved appliances, go to <https://www.dmepdac.com/dmecsapp/do/productsearch>, enter E0486 in the HCPCS Code field, click on the E0486 code that comes up in the list, and then hit the “GO” circle near the bottom of the page). This is not just the appliance design, but the specific “brand” of appliance AND often the lab that can fabricate it.

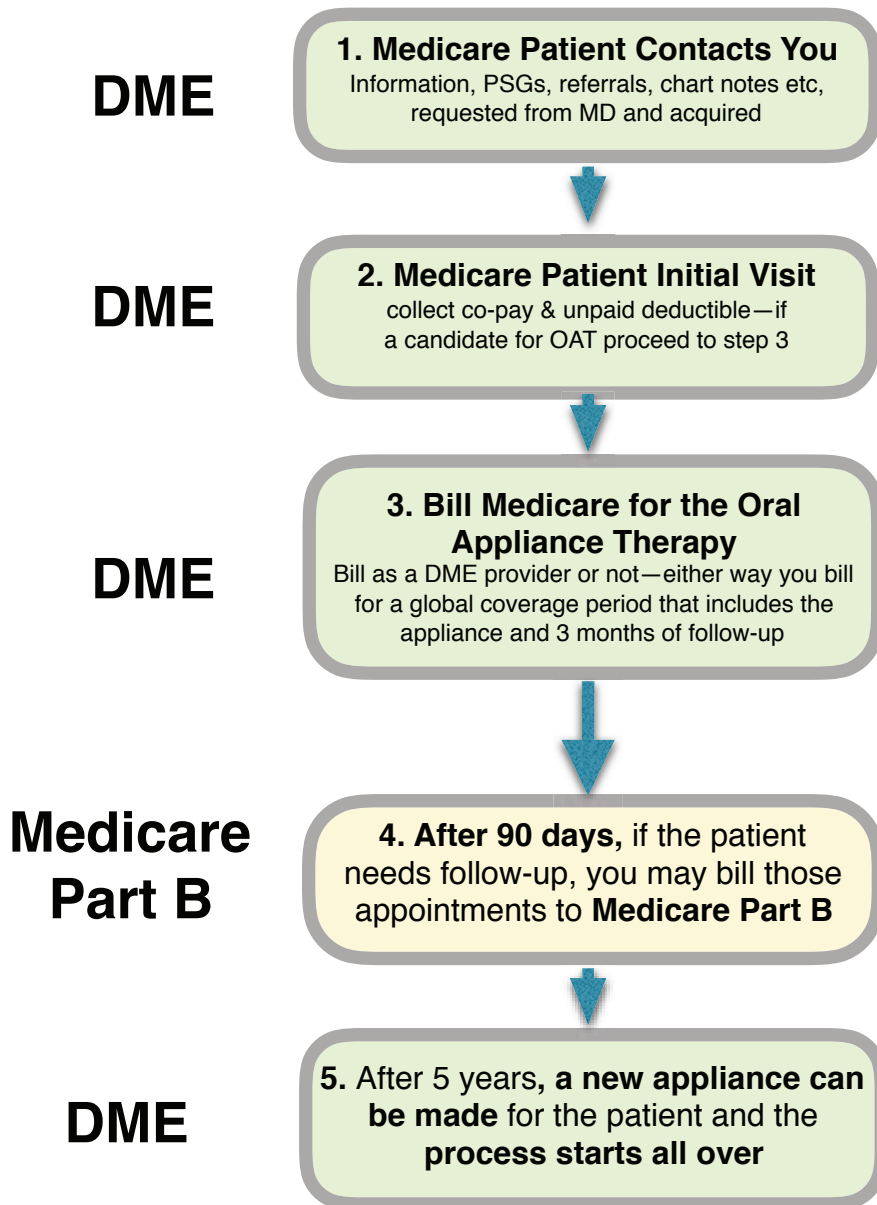
PDAC Medicare Pricing, Data Analysis and Coding

Product Name	Manufacturer/Distributor	Model Number	HCPCS Code	Effective Begin Date	Effective End Date	Comments
ADJUSTABLE DORSAL APPLIANCE	SPACE MAINTAINERS LABORATORY	63225A	E0486	01/23/2012		
ADJUSTABLE DORSAL APPLIANCE/ PMT BASE	SPACE MAINTAINERS LABORATORY	63225	E0486	01/25/2012		
ADJUSTABLE PM POSITIONER	DENTAL SERVICES GROUP		E0486	09/14/2011		
DORSAL APPLIANCE	DYNAPLEX	# 01108	E0486	09/30/2011		
DORSAL APPLIANCE DUAL LAMINATE	DYNAPLEX	# 0110D	E0486	09/30/2011		
DORSAL APPLIANCE THERMAL	DYNAPLEX	# 0110T	E0486	09/30/2011		
HERBST SLEEP APPLIANCE	GREAT LAKES ORTHODONTICS LTD	I 102	E0486	12/27/2011		
KLEARWAY APPLIANCE	GREAT LAKES ORTHODONTICS LTD	W 101	E0486	09/22/2011		
RESPIRE BLUE SERIES	RESPIRE MEDICAL	R8001	E0486	11/07/2011		
SOMNODENT CLASSIC	SOMNODENT INC	MAS RXA HARD ACRYLIC	E0486	09/22/2011		
SOMNODENT EDENTULOUS CLASSIC	SOMNODENT INC	MAS RXA HARD ACRYLIC EDENTULOUS	E0486	09/22/2011		
SOMNODENT EDENTULOUS FLEX	SOMNODENT INC	MAS RXA SOFT FLEX EDENTULOUS	E0486	09/22/2011		
SOMNODENT FLEX	SOMNODENT INC	MAS RXA SOFT FLEX	E0486	09/22/2011		
TAP	AIRWAY MANAGEMENT INC	TAP 3 ELITE	E0486	10/05/2011		
TAP	AIRWAY MANAGEMENT, INC	TAP	E0486	03/02/2011		
TAP	AIRWAY MANAGEMENT, INC	TAP 3	E0486	03/02/2011		
TAP 3 - ELITE	SPACE MAINTAINERS LABORATORY	63316E	E0486	01/25/2012		
TAP T	AIRWAY MANAGEMENT, INC.		E0486	01/18/2007	12/31/2008	
TAP- 3	SPACE MAINTAINERS LABORATORY	63316	E0486	01/26/2012		
TAP-TL	SPACE MAINTAINERS LABORATORY	63313	E0486	01/25/2012		
THE SUAD DEVICE	STRONG DENTAL LTD	SUAD DEVICE	E0486	11/07/2011		
THE SUAD ELITE	STRONG DENTAL LTD	SUAD ELITE	E0486	11/07/2011		
UCLA MODIFIED HERBST	SPACE MAINTAINERS LABORATORY	63250	E0486	01/23/2012		

3. The global DME code “E0486” must be used for the custom appliance.

The Medicare Patient Flow Chart for OAT

This can seem so incredibly complicated when you first start looking into Medicare. In order to help me grasp the Medicare process that our patients (and their claims) go through, I created a little flowchart for myself (I’m super visual!!). Understanding this process will help us take the small portion of information we need from the gargantuan amount of Medicare information available. Let’s go through it together so we don’t get overwhelmed. The green boxes on the flowchart are what you bill through DME, and the yellow box is what you bill to Medicare Part B...



Medicare Flowchart Steps

As you can see, most of the time that you are dealing with Medicare you will be working with DME (Durable Medical Equipment). DME is very straight forward compared to Medicare Part B. There are some dentists who only contract with Medicare DME and never bill Medicare Part B. These dentists just have “case fees” that cover all of treatment, and don’t plan on billing Medicare Part B for adjustment appointments after the 90 day window. If they have a patient that needs an adjustment after 90 days, they don’t charge them an appointment fee, and thus save themselves having to worry about the complexities of Medicare Part B. Here is the breakdown of the flowchart to help you get the flow of it ;-D.

1. Medicare Patient Contacts You—this could be a current patient that you have, or someone referred to you. Download a current LCD (local coverage determination) from your Medicare Jurisdiction to determine what is required in order to be paid by Medicare DME. Then when you schedule a Medicare patient, get the following information on their OAT Patient Intake Form (see example in “Examples of Forms and Letters” at the end of this book):

- A referral from the patient’s MD
- A copy of the original, baseline sleep study/PSG (subsequent sleep studies will not work as they have CPAP titration information on them). Usually how old the baseline sleep study is does not matter...although it may matter for how your doctor treats the patient (see “Spencer Study Club” level 2 “How to read and understand sleep studies”).
- A chart note from the MD *prior* to the PSG discussing sleep issues (typically the chart note where the physician refers the patient for the sleep study)
- A chart note from the MD *after* the PSG with diagnosis of OSA (this chart note must be within 6 months of when you plan to fit an oral appliance) to show continuing need
- A Detailed Written Order (DWO) from the referring MD
- Check to determine if criteria are met according to the LCD
- Check to see if patient had a CPAP trial or is still using CPAP (Continuous Positive Airway Pressure)
- Check to ensure the sleep study meets requirements for the severity of sleep apnea, according to the Medicare guidelines for your jurisdiction.
- Check that the referring MD is a Medicare provider.
- Then schedule the Patient for an initial evaluation.

2. Medicare DME Patient Initial Visit—collect the patient’s co-pay & unpaid deductible (if there is one). At the initial evaluation, if your doctor determines that the patient is a candidate for oral appliance therapy and meets all the qualifications for their appliance to be covered by Medicare, schedule them for their fitting.

3. Bill Medicare DME for the Oral Appliance Therapy at the Fitting Appointment—whether you bill as a Medicare DME provider or not, you will bill for a global coverage period that includes the appliance and 3 months of



follow-up. As a side note, make sure that when the patient is fit with their appliance that the patient is given a Proof of Delivery form (see example in “Examples of Forms and Letters” at the end of this book). They must sign the form and you must keep a copy in the patient’s chart. Medicare requires this form and when they periodically request records, this form must be included to prove delivery.

4. After 90 days, if the patient needs **follow-up**, you may bill **Medicare Part B** for those appointments. The guidelines you need to do this are listed in the Medicare Part B chapter of this book. In some of the practices Jamison consults, they have elected to just charge their patients (whether they are Medicare or regular insurance) a comprehensive fee that covers everything, and not bill for follow up visits. This may change down the road but at this point not having to hassle with Medicare Part B is a blessing to all concerned. This may be how you choose to start out too...or work with a reputable billing company who knows all of the ins and outs.
5. After 5 years, a **new appliance can be made** for the Medicare patient and the process starts all over again (unless the government changes all the rules before then!).

Make sure that when the patient is fit with their appliance that the patient is given a Proof of Delivery form (see example in “Examples of Forms and Letters” at the end of this book). They must sign the form and you must keep a copy in the patient’s chart. Medicare requires this form and when they periodically request records, this form must be included to prove delivery.

Common Medicare Questions

Are dentists required to bill Medicare for services given to their Medicare patients?

Every single dentist, even those who are not “enrolled” in the Medicare program, is required to submit Medicare claims when they provide oral appliance therapy to their Medicare patients. This rule has only two exceptions that I know of:

1. You, the dentist, officially opt out of the Medicare program (more on this in a second), or
2. You have your patient sign an Advance Beneficiary Notice of Noncoverage and have them select the option that directs you to not submit their claim to Medicare.

If you do not do either of these two options you’re required by law to submit Medicare claims for your patients.

Is there a difference between “opting out” of Medicare and just not enrolling in the Medicare program?

Yes! These are not the same things. When you do not enroll in the Medicare program, you are still obligated to submit claims to Medicare when you see a Medicare patient (unless your patient has signed an ABN). So in other words, unless you opt OUT, you’re IN!

The Medicare Benefit Policy Manual, Chapter 15, Section 40 says, “The only situation in which non-opt-out physicians or practitioners, or other suppliers, are not required to submit claims to Medicare for covered services is where a beneficiary or the beneficiary’s legal representative refuses, of his/her own free will, to authorize the submission of a bill to Medicare.” In other words you must have your patients sign an ABN and select that they don’t require you to bill Medicare for them. It is actually required by law that you provide your patients with the ABN if you are not enrolled in Medicare, and you are providing a service to them that is normally covered by Medicare.

If you don’t want to deal with Medicare at all in your practice then you need to officially opt out of the Medicare program entirely. When you do that, **no services** you provide are covered by Medicare and so no payment is made by Medicare to you or to your Medicare patient unless they are in need of emergency care (which would never happen in the case of OAT). If this is what you want to do, you must renew your opt-out every two years to keep your status.

How do I opt out of Medicare?



To opt out of the Medicare program:

1. You will need to file an affidavit with Medicare that you agree to opt out of Medicare for a period of two years and meet certain other criteria,
2. You will need to have private contracts with all your Medicare patients to whom you provide services that would normally be covered by Medicare. When your patients sign the contract, they agree to give up Medicare payment for your services and to pay you your fees without regard to the Medicare Fee Limits.
3. If you opt out of Medicare you cannot elect to opt out of the program for some services and not others, or for some Medicare patients and not others—you are, in effect, opting out of everything Medicare for all Medicare patients.
4. Only individual doctors or dentists may opt out of the Medicare program. If you are in a group practice, the opt-out will only apply to you and not the whole organization.

We recommend that you not make the decision to opt out hastily. We did this a long time ago, and then when we decided that it would be better for us and our patients if we “opted back in” we found out that we couldn’t until our **2 year clock** had run out. You would think that Medicare would welcome you back with open arms...but that’s not the case. So choose wisely.

Are there any circumstances where dentists can collect the full amount of the charges for oral appliance therapy from a Medicare patient?

Hmmmm, good question! If you decide to be non-participating with non-assignment of claims (for **Medicare DME**), you can collect the full amount of your fees directly from your patient. Your patient would sign an ABN and would then be reimbursed by Medicare DME according to the Medicare DME POS Fee Schedule (which will probably be less than what they paid). Many dentists decide to set things up this way and there are many advantages. The disadvantage is payment goes directly to the patient, so most dentists will collect up front from the patient. Some patients may not be able to do this. Our Idaho practice is “participating,” but that doesn’t mean that would be the best decision for your office.

The other option for you to collect your full fee is for you to opt out of the Medicare program and enter into private contracts with your Medicare patients and have them sign an Advance Beneficiary Notice of Noncoverage.

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Medicare DME POS

When it comes to Oral Appliance Therapy almost everything that we bill as dentists to Medicare is through DME POS (for the purposes of this book, anytime you see Medicare DME, I mean Medicare DME POS—it's the same thing). There are many dentists who don't even bother with Medicare part B, and either bill a comprehensive fee that covers all adjustments up front, or they use an ABN to bill follow-ups as a non-participating provider (explained in Medicare Part B). Let's cover a few things about DME POS.

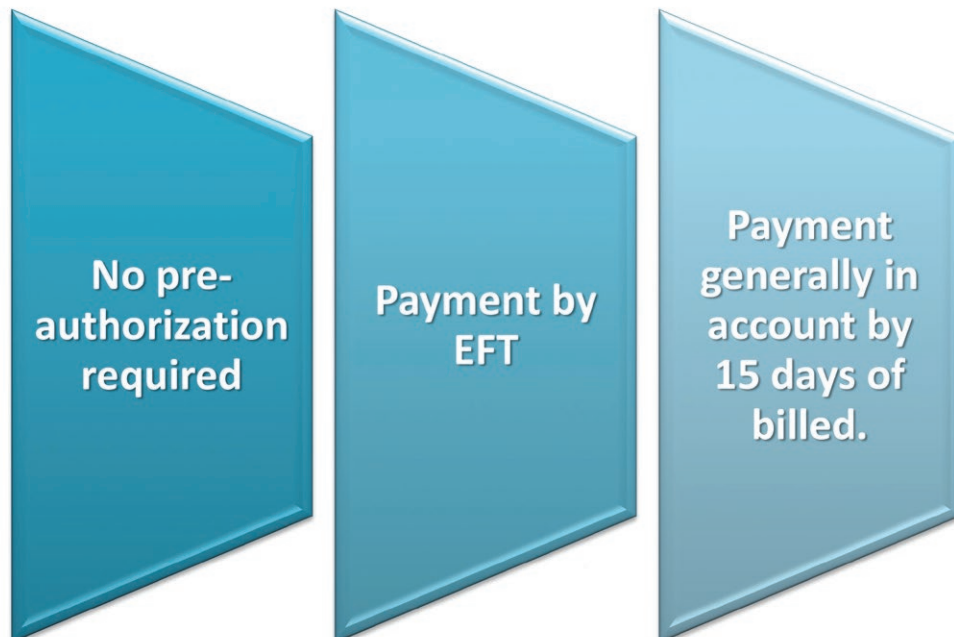
Becoming a DME Provider

Jamison and I highly suggest taking the time and effort to become a DME provider with Medicare. It streamlines the claims submission and your claims are paid within about 2 weeks. You can submit the DME codes without being a provider, but in our experience claims are processed faster and correctly when you are contracted. Being a dentist, your claims could get misrouted and it takes a long time to get them straightened out to the right department when that happens.

As you prepare to start the process of getting set up as a DME supplier, we have a few suggestions:

1. If you can, **hire a company to do it for you!!** It is well worth the money to avoid the headache because an experienced billing company will make fewer mistakes and get it done in a more timely manner than you could. Trust me, this is the voice of experience, from all the insurance experts I've spoken with, talking to you!

Benefits of Medicare



2. If you decide to do it alone, be prepared for the process...it can take **7 to 9 months** to get it set up. You will decide on which AO you want to work with (Accreditation Organization), submit applications etc. to them and then have at least one unannounced site visit (which happens whether you do it alone or have a company do it for you).
3. There are several forms that need to be submitted, and there is a certain order as well. For example, you can't submit the CMS-855S to the National Clearing House until your practice is accredited with your AO.
4. When you submit the applications to the AO of your choice, in our experience, they don't go through your entire application to check for errors. Instead they go through it until they come to an error and send it back for you to fix. Thus it may take several back and forths before they go through the entire application and find all the errors. It can be frustrating, but remember it is worth it in the end!

To enroll in the Medicare program as a DME supplier, you need to obtain an NPI number (which you probably already have) and then submit several forms. A helpful description of the process is located on the CMS.gov site: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Basics_FactSheet_ICN905710.pdf.

Choosing to be Participating or Non Participating as a Medicare DME Provider for Oral Appliance Therapy

When you sign up as a Medicare DME provider for oral appliance therapy you will automatically be signed up as “non-participating,” unless you select to be “participating” on the application. If you are initially non-participating, you may choose to become participating at any time by filling out a simple form and sending it in. The choice to be participating lasts for 1 year. Once you are participating you *cannot* change your participation until you reach your year mark.”

To Participate or Not To Participate:

Here is another decision your office has to make...and it's a pretty big one.

Participating = you will accept the Medicare fee schedule amount, for your jurisdiction, as the fee in full for the oral appliance therapy and all follow up for 90 days. You may collect the patient's co-pay and/or deductible if they have one, but nothing above the allowed amount. Payment from Medicare will go directly to you.

Non-participating = you may charge whatever you want for the appliance therapy, and the patient will be responsible to pay the difference between the Medicare allowable and your charge. Payment will go directly to the patient. As such, most dentists charge the full fee “up front,” and the patient is reimbursed some of the money from Medicare. Or, the dentist could estimate what the patient will owe and have them just pay that amount initially, and trust the patient to pay them the rest once they are paid by Medicare.

Now it's about to get a little confusing, so tap into your super hero mind skills and hang on! **You may choose to be non-participating, but then elect on a claim by claim basis to "accept assignment."**

Accept Assignment = where the money goes. Think of it as "accepting the check." If you are participating you automatically accept assignment and the check goes to you. If you are non-participating the money automatically goes to the patient UNLESS you check the "accept assignment" box on the claim form, which you may do on a case by case basis.

As a non-participating provider when you select accept assignment you are in effect choosing to be participating for that specific case.

In other words, when you check "accept assignment" that means you are choosing to accept the Medicare DME fee schedule as payment in full, and not bill the patient for anything above the Medicare fee schedule. Again, you can do this on a case by case basis.

So what do we do? Currently, we choose to be participating providers...but many, if not most, dentists doing dental sleep medicine choose to be non-participating so that they can charge what they want, and/or so they aren't locked into Medicare's DME POS fee schedule.

The reason we choose to be participating providers is that we look at Medicare as marketing. A large percentage of sleep doctors and other doctors' patients are on Medicare. Many of these patients would struggle to pay high up front fees. Many, where we practice, would struggle to pay hundreds of dollars more than Medicare covers. In other words, many patients in our community simply would not enter treatment if we weren't participating providers. Since we are, there are very few hurdles for these patients to get over, financially, and the vast majority enter treatment. This helps us build relationships with our medical community, and of course allows us to help a lot more people.

So why not be non-participating and just select "accept assignment" when you have a patient who can't afford to pay more? There is no problem doing that, and that may be exactly the right choice for your office. If you work with a reputable billing company, they will help you make this decision.

Here is maybe the best Medicare DME strategy:

I know some practices who are **non-participating but *always* accept assignment**. What the heck? The reason they do this is pretty smart. You see, Medicare can change their fees up to 4 times a year, but you only get 1 time a year to decide if you are participating or non-participating. So what if Medicare DME changed their fee schedule tomorrow to only pay \$400? Could you afford to treat people at that rate? Of course not! But if you have elected that year to be participating, you would be forced to accept that fee, or just not accept any Medicare patients till your year clock ran out and you could elect to be non-participating. One way to avoid this is to be non-participating, but accept assignment on all claims (meaning the benefit to the patient is *exactly* the same as if you were participating), and retain the freedom to *not* accept assignment if Medicare does something crazy with their fee schedule.



Clear as mud? You might need to read through this section a few times...sorry :-) All this stuff makes my head spin too...

Sending Claims to Medicare DME

The procedure to file claims to Medicare is the same as for normal insurance. Just make sure you check what DME MAC jurisdiction you are in so you know where to send your claims. If you have questions about how to fill out the HCFA forms, please refer to the chapter titled “Submitting a Claim”.

All You Ever Wanted to Know About an ABN...

For those of you that want to follow the model of billing the appliance to Medicare DME and then using ABN's after the 90 days to bill for follow up appointments, here is some info on how to use an ABN.

What is a Medicare Waiver/Advance Beneficiary Notice (ABN)?

An ABN is a Medicare form (standard government form CMS-R-131), given to the patient before they receive certain items or services, notifying them that:

- Medicare is likely to deny payment for that specific procedure or treatment.
- If Medicare denies the claim, they will be personally responsible for full payment of the item or service.

An ABN gives the patient the opportunity to accept or refuse the items or services and protects them from unexpected financial liability in cases where Medicare denies payment. It also offers them the right to appeal Medicare's decision.

You must use an ABN if:

- Your dentist is not enrolled as a Medicare provider.
- The oral appliance selected by your dentist and/or the patient is not a PDAC-approved device.
- If oral appliance therapy is not considered medically reasonable and necessary (such as when treating a patient for snoring that does not have OSA).

If you have an ABN on file for a patient, but fail to write in the modifier “GA” in the modifier section of the HCFA form, then the claim will be denied as your responsibility and you can't bill the patient! Those 2 little letters are pretty important!”

You can also use the ABN as a tool to let your Medicare patients know of a potential financial obligation. When you use the ABN in this way, voluntarily, you aren't required to follow the issuance guidelines. This means that your patient doesn't have to select an option on the document and sign it.

When the patient signs an ABN (in one of the 3 cases described above that require you to use an ABN), you need to use the special modifier “GA” with your code to tell Medicare that you have an ABN on file. When Medicare denies the claim because it is not a covered service and they see the “GA” modifier they will deny it as the patient's responsibility, allowing you to collect the fee from the patient. If you have an ABN on file for a patient, but fail to attach the modifier to the code, then the claim will be denied as your responsibility and you can't bill the patient. Those 2 little letters are pretty important!

What are the patient's options if they receive an ABN form?

They have the option to receive the items or services or to refuse them. In either case, they should choose one option on the form by checking the box provided, and then signing and dating it in the space provided.

If they choose to receive the items or services:

- They must check “Option 1, YES.”
- Sign and date the form.
- The claim will be sent to Medicare. They may be billed while Medicare is making its decision.
- If Medicare does pay, they will be refunded any payments that are due to them.
- If Medicare denies payment, they will be personally responsible for full payment.
- They will have the right to appeal Medicare's decision.

If they choose *not* to receive the items or services:

- They must check “Option 2, NO.”
- Sign and date the form.
- Their claim will not be sent to Medicare.

What if a patient refuses to sign an ABN, but they want the items or services anyway?

If they refuse to sign, one of two actions will take place:

- You may decide not to provide the items or services, **OR**
- A second person will witness the patient's refusal to sign the agreement, and they will receive the items or services. However, the patient may be held liable because they have been notified of the likelihood of a Medicare denial.

When a patient is liable for payment because they signed an ABN, how much can they be charged?

When a patient signs an ABN and becomes liable for payment, they will have to pay for the item or service themselves, either out-of-pocket or by some other insurance coverage which they may have in addition to Medicare. **Medicare fee schedule amounts and balance billing limits do *not* apply.** The amount of the bill is a matter between you and the patient. If this is a concern for the patient, you may want to offer a cost estimate before they sign the ABN.

Do ABNs mean that Medicare is reducing coverage?

No. ABNs do not operate to reduce coverage at all. Only if and when Medicare does deny the claim, do patients become liable for paying personally for the service or item. If Medicare decides to pay the claim, your patient has lost nothing by signing the ABN.



Notes

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Medicare Part B

[*Warning!!!* A bunch of this information is about to confuse the crud out of you!! Some of it will seem inconsistent with what was just discussed with regard to “participating and non-participating” as a Medicare DME provider. That’s because it is! Medicare Part B and Medicare DME are *not* the same thing, and do *not* have the same rules. Medicare Part B is NOT for billing out the oral appliance or follow up for 90 days. You may choose to not deal with Medicare Part B at all...which if you’re just getting started may be very wise for keeping your sanity. And by the way, when you go to a conference and someone is talking about billing oral appliance therapy and they say something that doesn’t make sense, make sure you know if they are referring to Medicare DME rules or Medicare Part B rules.]

If you are **not** doing much TMJ in your dental practice then the only reason you would need to bill Medicare part B is to bill follow-up adjustments after the 90 day global period. If you’ve decided not to do this then you can totally skip this whole section! Lucky you! For those of you who are die-hard, ready to jump into Medicare with both feet...this section’s for you!

Participating and Non-Participating Providers

A Medicare Part B *participating provider* is a doctor who enters into an agreement to accept Medicare assignment for all covered services provided to all patients who have Medicare coverage. This provider also agrees to accept Medicare Part B’s total amount as payment in full with the exception of deductible and coinsurance. Basically that means that if you are a participating provider, you agree to accept the reimbursement that Medicare allows and not charge the patient any additional amount. Reimbursement checks are sent directly to you as the provider.

One little interesting tidbit of information for you: Medicare’s most recent report for CY 2001 (calendar year 2001), indicated that 88.7% of all physicians, practitioners and suppliers were Medicare participating providers.



Dentists who are participating providers with Medicare Part B can collect 100% of the Medicare allowed fee on their assigned claims, whereas non participating providers can only collect 95% of the Medicare allowed fee (from Medicare). Another advantage of participating with Medicare Part B is only needing one fee schedule for your practice and the fact that Medicare will provide automatic crossover of Medigap claims (a secondary private insurance that patients with Cigna Medicare, Jurisdiction C can purchase).

A “*non-participating provider*” is a doctor who chooses not to enter into a participating provider agreement as described above. This status receives a 5% reduction in payments.

Non Par (non participating) Part B providers may benefit from the ability to collect up to the Limiting charge which is 9.25% above the Medicare

Participating Allowed fee when a claim is filed without accepting assignment. However, this gets a little confusing because the allowed fee for assigned claims is 5% less than that for participating providers. Non participating physicians must maintain two fee schedules; a standard fee schedule for their Non-Medicare patients and a fee schedule of Limiting Charges for Medicare patients (115% of the Non Par Allowable which is 95% of the Par Allowable). That may take a bit to wrap your brain around, if you're like me! So let's do a math problem to make it a little clearer ;-D:

Participating Provider fee example:

- You charge \$150 for a code.
- The participating allowable for the item is \$100.
- Medicare pays 80% of the \$100 (which is \$80).
- The patient or supplemental insurance pays \$20, and you write off \$50.

Non Par Provider, *Accepting Assignment*, fee example:

- You charge \$150 for a code.
- The non-participating allowable for this code is \$95 (95% of their Participating Provider allowable).
- Medicare pays 80% of the \$95 (which is \$76).
- Because you accepted assignment the patient (or supplemental insurance) pays you \$19 and you write off \$55.

Non Par Provider, *Does NOT Accept Assignment*, fee example:

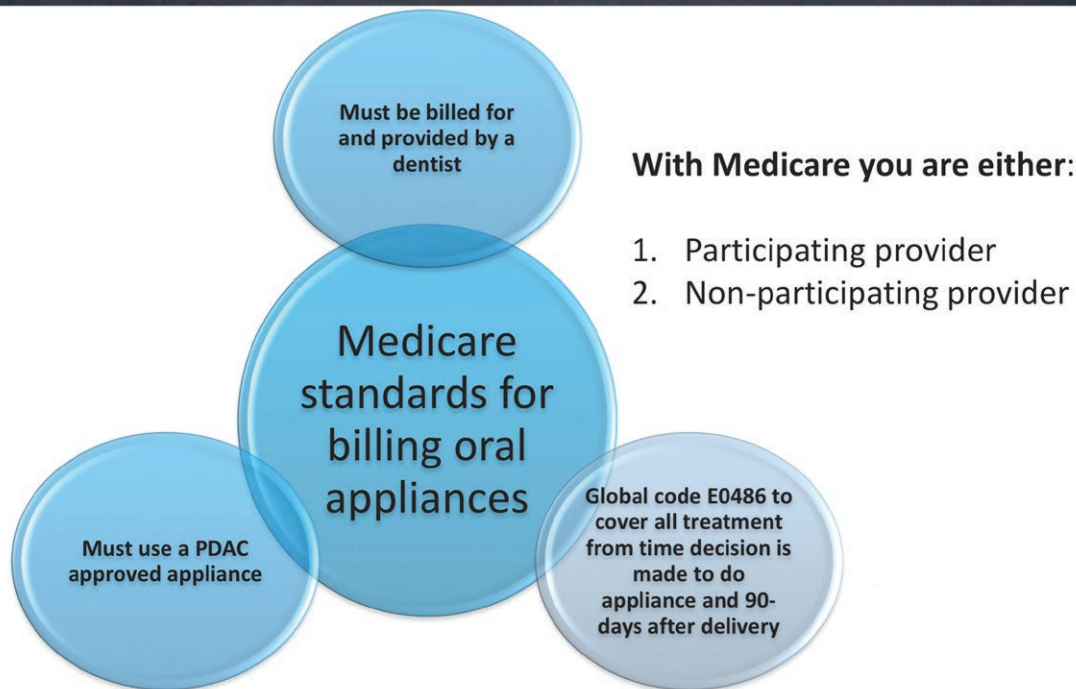
- You normally charge \$150 for a code, but because you are a non-participating provider and you aren't accepting assignment, you may not charge more than 115% of the \$100 allowed amount, so you charge \$115.
- The non-participating allowable for this code is \$95 (95% of their participating Provider allowable).
- Patient pays you no more than 115% of the allowable fee (\$95) which is \$109.25, and you write off \$40.75.

Non par providers also have to be very careful to monitor the Medicare limited charge amounts, which change periodically, to make sure they are not charging more than what Medicare allows. Medicare doesn't consider "being unaware" of changes to their fee schedule an adequate excuse, and if you accidentally overcharge, they will not only recoup the overpaid fees but will also audit and fine you. Trust me, you really don't want to go down that road.

The 20% coinsurance is based on 20% of the Medicare approved amount (not 20% of the billed amount). Private insurance policies will usually reimburse the patient for the 20% coinsurance and the deductible. Some private insurance policies may reimburse the patient for services not covered by Medicare.



Medicare Standards



Assignment and Non Assignment of Benefits

When you accept assignment, you agree to bill the patient only for any coinsurance or deductible that may apply, and accept the Medicare payment as payment in full. Medicare usually pays you 80% of the approved amount of services after the patient meets the annual Part B deductible (currently \$166—but this changes every year). The patient pays the other 20%, or they may have a supplement or secondary insurance to cover the remaining percentage.

Assignment

Under the Medicare program, you have two options for reimbursement. The first is accepting assignment of benefits. Accepting assignment on a Medicare Part B claim can be a definite advantage to both you and the patient. The Medicare claim itself is a legal agreement between the doctor, the patient and Medicare, and it carries with it specific terms that must be observed or the Medicare Fraud Department could get involved, so it pays to know what you are doing.

Assignment of benefits applies to all participating providers and also to non-participating providers who may accept assignment on a case-by-case basis. If you accept assignment, the Medicare payment will be made directly to your office.

Item 27 on the CMS-1500 claim form (a little box that says “Accept Assignment?”) allows you to indicate whether you accept or do not accept assignment. When accepting assignment, you may bill the patient for 3 things:

1. the 20% coinsurance,

2. any unmet deductible,
3. any services that are not a covered benefit by Medicare.

The difference between the billed amount and the Medicare approved amount cannot be billed.

On assigned claims you, as the provider, are bound by the assignment agreement even if no payment is issued as a result of the payment being applied toward the patient's annual deductible. You must still accept Medicare's approved amount as payment in full, but the patient can be billed for their deductible amount.

You can collect charges from the patient for services that are denied as not covered by Medicare even though assignment was accepted on the claim. For example, if your office billed out a dental cleaning as well as a follow-up appointment for their sleep appliance, you can collect money for the dental cleaning because it is not a covered Medicare benefit. In this example you would still accept assignment on the claim and that would apply to the follow-up appointment but not the dental cleaning, even if they are on the same bill. Assignment cannot be canceled once the claim is processed and the carrier has sent a notice of determination to both parties. This also applies to all future resubmissions, adjustments, and appeals of the claim, in case of denial or underpayment. If you are a participating provider, you may not cancel assignment as this would be a violation of the participation agreement.

If you decide to hire a third party billing service to handle your claims, keep in mind that you are still ultimately responsible for the activities of the billing service you hire.

If a provider consistently violates the assignment agreement, the carrier may, with concurrence of the Centers for Medicare & Medicaid Services (CMS), refuse to pay assigned claims submitted by that provider. Public Law 95-142 states that any person who knowingly, willfully and repeatedly violates the assignment agreement shall be guilty of a misdemeanor and subject to a maximum fine of \$10,000.00 and/or exclusion from the Medicare program for up to five years. This legislation also says that when convicted of a criminal offense related to their involvement in Medicare or Medicaid, they will be suspended from participating in both programs. This is serious stuff! Medicare does not mess around, so you will want to be sure you are in compliance with the assignment agreement.

If you decide to hire a third party billing service to handle your claims, keep in mind that you are still ultimately responsible for the activities of the billing service you hire. Make sure you get references and do your research so you can be confident your billing service is above reproach in their billing practices. All good services will know that when you accept assignment they should not bill the patient for any amount above the 20% coinsurance and any unmet deductible. Jamison discusses this in detail in the Spencer Study Club.

Keep in mind that assignment also means you are telling Medicare where they should send their reimbursement checks. Accepting assignment means that they will send the check to you, regardless of whether you are participating or not. Participating providers automatically accept assignment—that's part of being a participating provider. If you are a non participating provider you can decide to accept assignment or not. Doctors that collect their fee up front from the patient usually do not accept assignment so the reimbursement checks will be sent directly to the patient. If you are a non par provider, but only collect the co-pay or partial payment from your patient you would typically accept assignment so the checks will be sent to you and you will know how much to balance bill the patient. Hopefully that makes sense!

Non Assignment of Benefits

The second reimbursement method you have is choosing to not accept assignment of benefits. You can only choose this method if you are a non-participating provider. When you do not accept assignment, the Medicare payment will be made directly to the patient.

In this case, there are a few rules. First, you may bill the patient no more than the limiting charge for covered services. Should you bill more than the limiting charge for a covered service, you will have violated the non-participating agreement and may be subject to fines or penalties. Not only that, but Medicare will recoup all over charges. We have also seen cases where Medicare has assumed that because the doctor billed more than the limiting charge for a single patient that they billed more than the limiting charge for ALL their claims and has recouped money on *all* the Medicare claims from their office. *Not a good thing!* To avoid this, check the Medicare limiting charges for the codes you bill at least once a month to ensure that they haven't changed. (Medicare likes to make changes and haven't been Johnny-on-the-spot at letting providers know.)

When you do not accept assignment on a Medicare claim, you are not required to file a claim to the patient's secondary insurance.

If you choose to be a non participating provider, you must still bill Medicare if you are enrolled and see Medicare patients, but you may decide on a claim-by-claim basis whether to accept assignment. It is good to remember that a claim on which you have accepted assignment will be paid at a higher rate than a non-assigned claim.



An exception to the non-participating agreement is that non-participating providers are required by law to accept assignment when the patient has both Medicare and Medicaid.

Primary Medicare Insurance

There are several options for primary insurance for anyone over the age of 65.

1. **Regular Medicare**—For our Idaho practice, our claims are handled by Medicare Jurisdiction D, managed by Noridian Medicare. Please see the Medicare Jurisdiction Map above to find out your jurisdiction and managing company.
2. **Medicare Advantage Plan**—If a person wants to pay an additional premium, they can have another company administer their Medicare benefits. This is sometimes called Medicare Part C, and allows a patient a little more personal service, sometimes better coverage, sometimes a different deductible, and sometimes a copay rather than a percentage. They pay an additional premium. In our experience, most “advantage plans” don’t seem to be much of an advantage and they can make rules separate from Medicare guidelines, like not covering an oral appliance if the AHI is over 40. However, if the Medicare Advantage Plan denies the claim you can appeal directly to Medicare, and it will then follow the Medicare rules...which is a hassle, but will work.

3. **Employer Insurance Coverage**—a person over 65 who is still working (by Medicare definition “*The Working Aged*”, can stay on their employer’s plan and not be required to have Medicare/be bound by the rules of Medicare).

Patients that are only Medicare (no Secondary Coverage)

If a patient comes in and only has **regular Part B Medicare**, there will be a “co-insurance” that they are required to pay (co-insurance is different than a co-pay). This is usually 20% of the Medicare allowable. You may bill the patient for coinsurance plus any unpaid deductible (currently \$166 is the annual deductible, but that changes every year so check the current deductible) and is based on the calendar year. You will need to check the patient’s deductible especially at the beginning of the calendar year and preferably before the patient comes in, to know what to charge them at the time of their visit.

If your patient comes in and has a **Medicare Advantage Plan**, but no secondary insurance, you will need to determine which plan in order to know what to charge them. You will be able to tell which Medicare Advantage Plan they have by reading the front & back of the patient’s Medicare card. These plans usually have a “co-pay” of a certain amount and it is usually listed on the card. The amount that should be paid on this patient’s plan should be entered into your patient accounting system so that it is available at the time of checkout. Each of these plans can set their own deductible, so the amount of the deductible needs to be verified when you are filling out your Verification of Benefits form. The Advantage plans will also have their own networks, so make sure you verify whether you are in-network or out-of-network with the patient’s particular advantage plan.

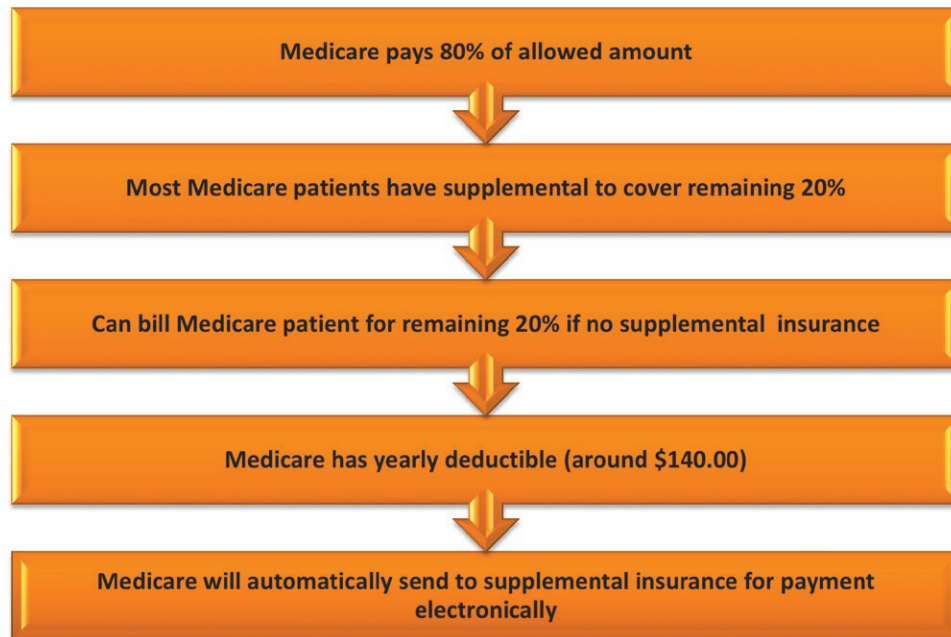
Secondary Insurance Coverage

Medigap—A Medigap policy is health insurance sold by private insurance companies to fill gaps in Original Medicare coverage. Some of those “gaps” are a patient’s deductible, co-insurance, and some Medicare non-covered services. ***In the case that there is a secondary insurance, no payment is taken at the time of service.*** However, the patient should be informed that there may be an amount due after both insurance companies have paid.

Employer Supplemental Insurance—Employer supplemental coverage is a supplemental health insurance plan offered by the patient’s or patient’s spouse’s former employer to supplement Medicare coverage. Some employers supplemental plans participate as complementary crossover plans (Medicare provides information to the supplementary company on what was approved and paid). If they do not participate, Medicare will still provide this info, but only ***if you provide Medicare with the supplementary insurance ID code and the group policy number.*** If the claim has been crossed over the name of the carrier will be at the bottom of the EOB line on the Medicare EOB.

Working Aged—see below (MSP-Medicare as a secondary payor).

Medicare and Supplemental Insurance



When Medicare is not Primary

Medicare as a Secondary Payor (MSP)

Medicare will be the secondary payer in some cases. The most common are:

- People who are 65 and still working and are covered under an employer's insurance plan (the working aged) or the spouse of someone meeting this description.
- People who receive services and are covered under automobile, no fault, or liability insurance. This is hardly ever the case with Oral Appliance Therapy patients (in fact I can't think of once!).
- People who receive services under the **Veteran Administration** (which have their own rules that vary from location to location, based on the medical director, directions from Congress, and who knows what else. We even worked with one VA that wanted the oral appliance therapy to go through Dental, which was a bad deal for the veteran, as most vets don't have dental coverage through the VA).

Billing When Medicare is the Secondary Payor

When Medicare is the secondary payer, the claim must first be submitted to the primary insurance company. If the primary insurer does not pay in full for the service, or even denies the claim, the claim may be submitted to Medicare for consideration of secondary benefits. When this happens:

- The Medicare claim must include a copy of the Primary EOB.
- A detailed explanation of the primary insurer's denial or payment codes *must* be submitted with the claim and primary EOB.

Billing Patients When Medicare is Secondary

You may bill the patient an amount up to the Medicare Fee Schedule allowance. However, if you collect the full amount, you must refund any amount paid by the primary or secondary payer that is above the Medicare Fee Schedule allowance. In other words, if you bill a non-Medicare Primary insurance company \$100 for a code (and that is the Medicare Allowable) and they pay you \$75, and then you bill Medicare and they pay you \$50, you must send \$25 back to Medicare. You can't collect more than the Medicare allowed amount from all insurance companies.

LCD for Obstructive Sleep Apnea

An LCD is basically the Medicare rules for determining coverage for a specific treatment, in this case Oral Appliance Therapy. Most insurance companies follow these rules, so it's good to be aware of them, even if you choose not to accept Medicare patients. I have provided a small portion of a Medicare LCD here as an example of what to look for when you go to print your own. The LCDs for each jurisdiction are very similar but not exactly the same, so you will definitely want to look up your region's LCD if you do not have it. Here's how to do that:

1. Go to www.cms.gov and hit the Medicare tab
2. In the search box on the top right, type in LCD
3. Click on the DME column (even if you are not a DME provider, you still search under DME because the codes you will be submitting are DME codes)
4. Find "Oral Appliances for Sleep Apnea" (the list is alphabetical)

Medicare LCD

Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.

A custom fabricated mandibular advancement oral appliance (E0486) used to treat obstructive sleep apnea (OSA) is covered if criteria A - D are met:

- A. The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea testing.
- B. The patient has a Medicare-covered sleep test that meets one of the following criteria (1 - 3):
 1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or
 2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
 - a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
 - b. Hypertension, ischemic heart disease, or history of stroke; or
 3. If the AHI > 30 or the RDI > 30 and meets either of the following (a or b):
 - a. The patient is not able to tolerate a positive airway pressure (PAP) device, or
 - b. The treating physician determines that the use of a PAP device is contraindicated.
- C. The device is ordered by the treating physician following review of the report of the sleep test. (The physician who provides the order for the oral appliance could be different from the one who performed the clinical evaluation in criterion A.)
- D. The device is provided and billed for by a licensed dentist (DDS or DMD).

If all of these criteria (A-D) are not met, the custom fabricated oral appliance (E0486) will be denied as not reasonable and necessary.

Custom fabricated appliances that achieve their effect through positioning of the tongue (E1399) will be denied as not reasonable and necessary. There is insufficient evidence to show that these items are effective therapy for OSA.

A prefabricated oral appliance (E0485) will be denied as not reasonable and necessary. There is insufficient evidence to show that these items are effective therapy for OSA.

Custom fabricated mandibular advancement devices that have not received a written coding verification from the Pricing, Data Analysis and Coding (PDAC) contractor will be denied as not reasonable and necessary.

5. Look through the disclaimers and accept at the bottom
6. Scroll down and you will see the requirements for your state.

Just as a side note, if you have a patient that lives in 2 places (such as a “snowbird” that spends the winters in Arizona, but lives in your home state the rest of the year) you must use the LCD of your patient’s declared home address, and submit the patient’s claim to their home jurisdiction. So be aware if your patients have 2 addresses or travel a lot, and clarify with them where they consider their home address to be. You will need to download another jurisdiction’s LCD if you have this happen, and abide by their rules for that patient.

General Medicare Tips

- Items not “categorically covered by Medicare” can be furnished to your patient at your regular rates. Medicare rules and limits do not apply to such items or services.
- An ABN with the charged service specifically listed is required in order to be able to bill the patient in full.
- Claims for Medicare patients are sent to your local jurisdiction provider. Refer to www.cms.gov for a list. The only exceptions we have found so far are:
 - Railroad Retirees—send to Palmetto GBA in Augusta, GA
 - United Mine Workers of America (UMWA)—sent to Ephraim, UT
- It is important to know the distinctions between Medicare Advantage, supplemental, and Medigap (you will have to know this as sometimes patients don’t).
- It is extremely important that we get thorough information about the patient’s coverage and enter that information correctly in order to:
 - Bill correct amounts and avoid reconciling and reimbursing.
 - Enter supplemental and medigap information on the claim so that Medicare will send it on to them and you avoid keeping track of the claim and submitting it to them yourself.
- Never guarantee coverage and don’t tell the patient that Medicare has denied a claim.
- Medicare doesn’t pre-authorize appliances so check to ensure that all the criteria are met. These documents must be kept in the patient’s file in case Medicare performs a record review. When they request a record review from you (and they will!), you will have 15 days to comply.
- It’s a great idea to hold **every sleep patient** to the Medicare standard as most insurance companies follow these Medicare guidelines.
- **Proof of Delivery Form** must be signed by the patient when their appliance is fit and then kept in the chart. Medicare will periodically request records and this must be included to prove delivery.



Notes

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Conclusion

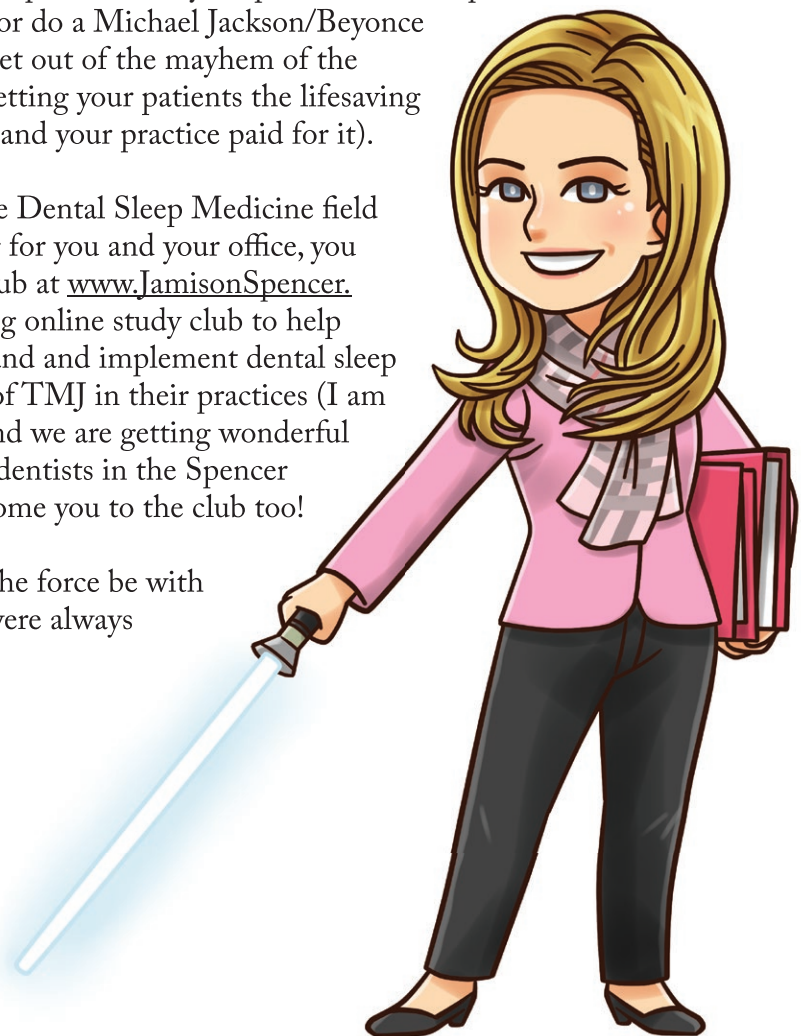
Okay. Now you know everything there is to know about insurance and Medicare....I wish! But at least you know enough to get you started on the right foot. If you decide to start off with a billing company, you know the questions to ask, the schemes to watch out for and some of the red flags to alert you to some unethical behavior. I highly suggest working with a great billing company especially when you are getting started. You can learn from them as you get your feet wet and still be ensured you are doing everything correctly, before you go it on your own.

If you want to do it yourself, I know the tools and information in this book will be a great help to you and assist you in being organized and thorough. Just remember, you can never have too much information and you will never know everything because the insurance world is always changing and evolving, so be prepared for an ongoing process of learning and detective work—and make it fun whenever you possibly can!

My biggest tip for you is to stay curious and flexible. If you get frustrated, step back for a second and say to yourself, “Huh! That was transcendently interesting!” or have a fun phrase that you can read or say to break your mental frustration and keep yourself out of the perplexity of the process and focused on the **great good** you are doing for your patients and your practice. Stand up periodically and roll your head around, or do a Michael Jackson/Beyonce dance move or something to help you get out of the mayhem of the moment and stay fixed on the goal of getting your patients the lifesaving treatment they need (while getting you and your practice paid for it).

And if you are just getting started in the Dental Sleep Medicine field and would like the best clinical training for you and your office, you should check out the Spencer Study Club at www.JamisonSpencer.com. Jamison has developed an amazing online study club to help dentists and their offices learn, understand and implement dental sleep medicine *and* diagnosis and treatment of TMJ in their practices (I am a little biased, but it really is fabulous and we are getting wonderful reviews on it!). There are already *lots* of dentists in the Spencer Study Club, and we would love to welcome you to the club too!

Now go, my young padawan, and may the force be with you to become the Insurance Jedi you were always meant to be. It is your destiny.



Notes

[illegible]

Appendix A-Examples of Forms & Letters

HCFA Forms

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE ☒ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA ☐ (SSN) OTHER ☐ (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane

3. PATIENT'S BIRTH DATE 01/13/1941 M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Jane

5. PATIENT'S ADDRESS (No., Street) 145 Main St

6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street) 145 Main St

8. PATIENT STATUS Single ☐ Married ☒ Other ☐

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER IDA123456789

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Hammond, Richard

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DAYS OR UNITS H. PSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #

25. FEDERAL TAX I.D. NUMBER 123456789 SSN EIN ☐ ☒

26. PATIENT'S ACCOUNT NO. SKIN1234

27. ACCEPT ASSIGNMENT? YES ☒ NO ☐

28. TOTAL CHARGE \$ 3050.00

29. AMOUNT PAID \$

30. BALANCE DUE \$ 3050.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on file 1/2/13

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # (208) 376-3600 Craniofacial Pain Center of Idaho 8119 Ustick Rd. Boise, ID 83701

1234567890

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789A									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane										3. PATIENT'S BIRTH DATE 01/13/1941									
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Jane										5. INSURED'S ADDRESS (No., Street) 145 Main St									
6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 145 Main St									
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>										9. INSURED'S ADDRESS (No., Street) 145 Main St									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER None									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on file DATE 12/1/12										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature on file									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 01/13/1941										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 01/13/1941									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM 01/13/1941 TO 01/13/1941										17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM 01/13/1941 TO 01/13/1941									
18. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										19. RESERVED FOR LOCAL USE									
20. MEDICAID RESUBMISSION CODE 1234567890										21. PRIOR AUTHORIZATION NUMBER									
22. ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From 01/12/12 To 01/12/12										25. B. PLACE OF SERVICE 99203 GA									
26. C. PROCEDURE, SERVICE, OR SUPPLIES (Explain Unusual Circumstances) 70355 GA										27. D. DIAGNOSIS POINTER 120 00									
28. F. CHARGES 120 00										29. G. DAYS OR LATS 99 00									
30. H. EPST FARMY PGM 1234567890										31. I. ID. QUAL. 1234567890									
32. J. RENDERING PROVIDER ID. # 1234567890										33. BILLING PROVIDER INFO & PH # 1234567890									
34. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS Signature on file 1/2/13										35. SERVICE FACILITY LOCATION INFORMATION Craniofacial Pain Center 819 Ustick Rd Boise, ID 83701									
36. SIGNATURE OF PHYSICIAN OR SUPPLIER Signature on file 1/2/13										37. BILLING PROVIDER INFO & PH # Cameron Kuehne, DMD 819 Ustick Rd. Boise, ID 83701									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Date: ____/____/____

Needs Imaging	Needs Pano	NP Tracker	Chart created	Pprwk sent via	Staff Initials
---------------	------------	------------	---------------	----------------	----------------

Verification of Benefits Form

Patient Verification of Benefits

Patient Name: _____ **Date of Birth:** ____/____/____
Insurance: _____ **Effective Date:** ____/____/____
Policy #: _____ **Group #:** _____
Phone #: _____ **Call Ref #:** _____
Contacted: _____ ☐ In-Network ☐ Out-of-Network

ORAL APPLIANCE E0486--covered @ ____% Co-Insurance: \$_____

Authorization Required? ☐ Yes ☐ No **Diagnosis:** 327.23

Criteria: _____

Auth Phone#: _____ **Auth Fax#:** _____

Individual/Family Deductible: ____/____ Paid:\$____/____ To Meet: ____/____
 Individual OOP Max: ____/____ Met ____/____ If Met, Insurance pays @ ____%
 DME Benefit Max: _____ Met _____ Yearly/ Lifetime
 Calendar Year Plan? ☐ Yes ☐ No **Plan Year** _____ **to** _____

Patient's total anticipated OOP: \$_____

(ALL BENEFITS SUBJECT TO DEDUCTIBLE UNLESS OTHERWISE INDICATED)

Notes: _____

Benefit details of plan are provided as a courtesy. This is a description of benefits as of this date only and is not a guarantee of payment. Final determination of payment will be made by your insurance carrier at the time they receive the claim. In the event that no benefits are paid, the balance is the sole responsibility of the patient.

Date Verified ____/____/____ **Staff Initials** _____

Prior Authorization Request Form

Prior Authorization Request

Requesting Provider:	TIN:	Date:
Provider Address: 8119 Ustick Rd. Boise, ID 83704		
Contact Person: Rose Mary	Phone: 208-514-4739	Fax: (208) 376-3616

Patient Name:	Enrollee ID:	DOB:
Diagnosis:		ICD-9:

Referred to:	TIN:	Fax
Referral address:	Phone	
Facility	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Assume management
Procedure:	CPT Code(s):	
Date of Service:	Expedite Reason:	

DME Requests

HCPCS:	Description:	Length of Need:
Date of Service:	COST:	

Additional Information:

See Attached

Advanced Beneficiary Notice (ABN)

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- ☐ **OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Letter of Medical Necessity from Doctor

July 11, 2016

Blue Cross of Idaho
ATTN: Medical Management
P.O. Box 7408
Boise, ID 83707

Patient Name: John Doe
Member ID #: IDA12345678
DOB: 11/20/1966

To Whom It May Concern:

John Doe was referred to us by Dr. Bill Plunket for fitting of an oral sleep appliance for his diagnosis of obstructive sleep apnea.

Dr. Plunket recommended that John consider use of an oral appliance as an alternative therapy of treatment for his obstructive sleep apnea. John reported the use of CPAP for 3 months, in which he did not tolerate CPAP well because the presence of CPAP disturbed his sleep and he had an unconscious need to remove the apparatus at night. He reports and Epworth Sleepiness Scale score of 11.

John was fit with his oral appliance on October 7, 2008 and reports that his appliance has been effective in treating his obstructive sleep apnea.

When John came in for a follow up visit on December 6, 2011, he requested a replacement appliance because his current appliance is showing signs of significant wear. He is a strong bruxer so he would benefit from a dorsal appliance which will provide greater longevity. Therefore, please consider coverage of a replacement appliance as it is medically necessary for this patient.

Sincerely,

Cameron A. Kuehne, D.M.D.
Enclosures

Letter of Medical Necessity

July 11, 2016

Aetna
ATTN: Medical Management
Fax: 860-975-3234

Patient Name: Jane Doe
Member ID #: AAABBBB123456
DOB: 05/01/1960

To Whom It May Concern:

Jane Doe was referred to us by Bill Plunket, PA for fitting of an oral sleep appliance for his diagnosis of obstructive sleep apnea.

Bill Plunket, PA recommended that Jane consider use of an oral appliance as an alternative therapy of treatment for his obstructive sleep apnea. The patient has trialed CPAP but is unable to tolerate this treatment due to the discomfort caused by the chin strap and/or head gear and also the presence of the device disturbed or interrupted his sleep.

Please view the attached records and authorize this medically necessary care.

Sincerely,

Rose Mary Milner
CRANIOFACIAL PAIN CENTER OF IDAHO

Claim Appeal Letters

December 6, 2011

Blue Cross of Idaho
Attn: Blue Card Appeals
P.O. Box 7408
Boise, ID 83707

Member Name:
DOB:
Member ID #:
Date of Service: 04/26/2011

To Whom It May Concern:

Please accept this letter as our appeal to your decision dated August 25, 2011 to deny payment for a custom fit oral appliance, claim number “_____”. It is our understanding that based on additional information received you have determined that an additional payment is not available. Prior authorization was not received per a benefit check dated April 19, 2011, call reference numbers 1109097827/1109098381. At that time we were told that preauthorization for E0486 was not required, therefore no preauthorization was obtained.

In reviewing all the medical records for this patient, he has a valid sleep study dated October 23, 2009 with an AHI of 20.7, a valid referral for an oral sleep appliance which shows use of CPAP and intolerance due to the mask leaking, not able to get the mask to fit properly and discomfort caused by the strap or headgear. The device was ordered by a treating physician and was provided and billed by a licensed dentist.

Therefore, we are respectfully requesting that you reconsider your previous decision and allow coverage for this medically necessary oral appliance.

If you have any questions or need additional information, please contact me at (208) 514-4739.

Sincerely,

CRANIOFACIAL PAIN CENTER OF IDAHO

Rose Mary Milner
Insurance Specialist

Enclosures

March 29, 2016

Pacific Source Medicare
2965 NE Conners Ave
Bend, OR 97701

RE:
DOB:
ID#:
Auth Ref #: 183885

To Whom It May Concern:

We requested authorization for E0486, a custom oral appliance to treat Jane Doe's obstructive sleep apnea. This request was denied due to not meeting Medicare guidelines. According to the Medicare LCD (L28606) you quoted, this patient DOES meet these guidelines.

LCD (L28606) Letter A: The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea testing. You will locate this item on the hand written chart note dated 4/13/07, middle of page 2 down beginning with "sleep" and ending on page 3 bottom of page beginning with PLAN notes sleep study.

LCD (L28606) Letter B: "The patient has a Medicare-covered sleep test that meets **ONE** of the following criteria (1-3): (#2 requirement): The AHI or RDI is greater than or equal to 5 events and less than or equal to 14 events per hour with a minimum of 10 events and documentation of A. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; **OR B.** Hypertension, ischemic heart disease, or history of stroke." Jane Doe's AHI is 5.6, she had 11.0 arousal events per hour with a total of 32 abnormal respiratory events. This information is located on page 1 of the polysomnography report dated 7/3/2007 under SUMMARY. Under HISTORY of the same report you will find the co-morbidities of Excessive daytime sleepiness and depression. The co-morbidities are also listed under DIAGNOSIS #1 in the last sentence, "Also of note the patient has a markedly elevated Epworth Sleepiness Score of 19 and suffers from a panoply of other symptoms which are often exacerbated by poor quality sleep."

LCD (L28606) Letter C: "The device is ordered by the treating physician following review of the report of the sleep test." See Patient Referral For Oral Sleep Appliance form where Dr. Reeves referred the patient to our office on 12/4/12 after determining that she is intolerant to CPAP indicating that the patient was to be evaluated and fit with an oral appliance.

LCD (L28606) Letter D: "The device is provided and billed for by a licensed dentist (DDS or DMD)". The appliance is being provided and billed by Cameron Kuehne, DMD License number D-4227.

Please review this request with the above information and overturn your original decision and authorize this medically necessary care that is provided under her Medicare coverage.

Sincerely,

Rose Mary Milner
Insurance Specialist

Enclosures

Appliance Delivery Form

 <p>THE CENTER FOR SLEEP APNEA & TMJ</p>	
DELIVERY FORM	
DELIVERED TO:	DELIVERED BY:
Patient's Name:	Clinician's Name:
Date of Birth:	_____
Patient's Street Address:	Office Address:
City, State, Zip:	The Center for Sleep Apnea & TMJ 8119 W. Ustick Rd., Suite 103 Boise, ID 83704 Ph: (208) 376-3600 Fax: (208) 376-3616
Item Delivered: Oral Sleep Appliance-E0486	Quantity Delivered: One (1)
Description of Item/Type of Appliance: <input type="checkbox"/> EMA <input type="checkbox"/> <u>UCLA Modified Herbst Model # 63250</u> <input type="checkbox"/> SomnoMed <input type="checkbox"/> Dorsal <input type="checkbox"/> TAP III Elite <input type="checkbox"/> Other: _____	
Patient's Signature:	Date:
Clinician's Signature:	Date:
<input type="checkbox"/> <u>Appliance warranty given to patient</u>	
Clinician's initials:	Date:

Patient Financial Agreement



Sleep Apnea & Snoring
TMJ Disorders
Head & Facial Pain

Cameron A. Kuehne, DMD
Jamison R. Spencer, DMD, MS
Keith L. Stucki, DMD

CPC Financial Agreement

Total Cost Financed: _____

Down Payment: _____

Monthly Payment: _____ To Begin on _____ and continue until the
balance is paid.

A credit card on file will be charged out on the _____ of each month

_____	_____	_____
Signed (Patient)	Date	Printed Name

Appendix B-Suggested Spreadsheets

If you aren't tracking your practice and your patients, how will you know if you are growing the way you want to? How do you keep patients from falling through the cracks? Well, we've got a tracker for that!(In fact we have several!)

All of our trackers are excel spreadsheets that allow us to highlight and track information and keep patients from getting lost! These are just suggestions. Some of our trackers have TMJ patient information on them which you probably won't need. Feel free to modify them to work for how your office functions.

Pre-Authorization Tracker

This is an actual section of our pre-authorization Tracker, with the patient names blocked out. We have found this to be an extremely useful tool in keeping track of all the pre-authorizations we do. Let me explain it.

Date Sent	Patient Name	Date Scheduled	Insurance	Approved?	Code Requested	Notes	Notes	Notes	Sent by	Done by	
1/6/2016		01/11/16	Tricare		E0486		Not req'd as 2ndry		fax	rmm	
		to sch	Premera BC	yes	21499	2ndry pcy			fax	rmm	
		to sch	Moda Health	no	21499	Gap excp & auth			fax	rmm	
1/7/2016		to sch	Select Health	yes	E0486	no CPAP trial	Replacement OA		fax	rmm	
		01/13/16	AIM	yes	E0486	added provider			fax	rmm	
		to sch	UMR		E0486				fax	rmm	
		12/22/15	Mtn Co-op	yes	E0486				ph&fax	rmm	
		01/05/16	UHC	yes	E0486				web&fax	rmm	

- **Date Sent**—the first column is where we type in the date that the pre-authorization was sent. Depending on the insurance and when they are scheduled, if we haven't received the pre-auth approval, we follow-up with the insurance companies 1 week after we send a pre-auth to see where it is in the process.
- **Patient Name**—each of the lines in this column is for a different patient, and their name is put in this column
- **Date Scheduled**—this column is where we write down the date they are scheduled or “to sch” (to schedule), to help us know the timeline of the pre-auth and who we need to pass the patient back to. If it says “to sch” then we do the pre-auth and when we get the approval, we send it back to our New Patient Coordinator to call them and schedule. If they are already scheduled, we put the pre-auth with their new patient information and have it available for their appointment
- **Insurance**—the patient's insurance company
- **Approved?**—whether or not the appliance is approved
- **Code Requested**—the code that is being pre-authorized; in the chart above you will see E0486 and 21499. In our office we also do TMJ and the 21499 codes are the TMD appliance therapy pre-auths and isn't a code you will probably use.
- **3 Notes columns**—in these columns you should type any pertinent information to remind yourself about that pre-auth or that patient, that would be useful to reference back to in future conversations with insurance companies.

- **Done By**—if you have more than one person that is working on the insurance stuff or needs access to the tracker, this is where the initials of the person working on the pre-auth go.

New Patient Scheduling Tracker

The New Patient Scheduling Tracker in our office is compiled by the New Patient Coordinator. This spreadsheet helps us keep track of every new patient that calls our office, and is a valuable tool in our marketing efforts. It keeps track of:

- How many new patient calls we receive every day.
- First and Last names of callers
- Phone numbers
- Whether the patient is strictly a snoring patient (in our office we call that S-0 and just means they've never been diagnosed with sleep apnea, or they had a sleep test that came back negative for sleep apnea) or a Sleep Apnea Patient (S-1, meaning they've had a sleep study and know they have sleep apnea)
- How the patient heard about us
- The name of the referring doctor and their credentials (to help us know which ones are dentists, nurse practitioners, doctors etc)
- When their scheduled appointment is
- Whether they are DNS (did not schedule) or AP (has appointment)
- The patient's insurance company
- The staff member who took the call
- Which of our offices they are going to be seen at (Boise, or Nampa) and who decided that, and
- Any other notes that would be helpful in understanding that call

We love this tracker because it helps us determine our highest referral sources when it comes time to giving "Thank You" gifts, and helps us track our efforts in scheduling new patients.

Date of Call	Last Name	First Name	Phone	Type	Marketing	Last Name	First Name	Credentials	Appt	ACT	Ins	Staff	Referred/Doctor	Call Notes
9/8/2015	Raap	Aaron	(208) 860-4042	S-0	google				9/15/2015	AP	Cigna Select Health Med	dd	Boise-pt's choice	
9/9/2015	Seiber	Carol	(208) 870-2485	S-0		Michaud	Mark	MD		DNS	Adv	dd		Chose not to sch cuz of no ins coverage, but doesn't want
9/9/2015	Hellickson	Steve	(208) 890-8276	S-0	drive-by				9/21/2015	AP		dd	Boise-pt's choice	
9/10/2015	Bautista	Laurie	(208) 546-4096	S-0		Asay	Eric	DDS	9/21/2015	AP	BCID	dd	Stucki/Stucki	
9/10/2015	Jarrett	William	(208) 989-5225	S-0		Stucki	Keith	DMD	9/17/2015	AP	BCID	dd	Stucki/Stucki	
9/17/2015	Glatz	Abigail	(208) 870-2485	S-0		Blaisdell	Thomas	DDS	9/22/2015	AP	DAS	dd	Nampa-pt's choice	
9/22/2015	Seiber	Carol	(208) 870-2485	S-0		Michaud	Mark	MD		DNS	SH Med Adv	dd		Pt wanted to get PSG so she could get ins coverage
9/23/2015	Huffman	Nancy	(541) 868-5100	S-0		Helms	Jared	DO		DNS	Medicaid	dd		No response to msgs left; sent letter to notify Dr. Helms
9/30/2015	Fischer	Cody	(208) 602-3431	S-0	yellow pages					DNS		dh		Dad was looking to sch pt for PSG, adv him of Medibyte=n Rasmus phone #
9/1/2015	McCloy	Celeste	(360) 853-3588	S-1		Furner	Beverlee	NP	6/15/2015	AP	Aetna	dd	Nampa-pt's choice	
9/1/2015	Stone	Treasa	(208) 412-3927	S-1		Furner	Beverlee	NP	9/14/2015	AP	DAS	dd	Boise-pt's choice	
9/1/2015	Smith	Bret	(208) 972-2979	S-1		Hale	Jennifer	MD	9/10/2015	AP	BC	dd	Nampa-pt's choice	
9/1/2015	Sanders	Deborah	(208) 600-5804	S-1		Lam	Linda	DO	9/3/2015	AP	BCID	dd	Nampa-pt's choice	
9/1/2015	Prophet	Elicia	(208) 549-0766	S-1		Levenson	Darcie	PA	9/9/2015	AP	Medicaid	dd	Boise-mom's choice	
9/1/2015	Neumeister	Lynn	(208) 867-7316	S-1		Plummer	Patrick	MD	9/10/2015	AP	Medicare/MOH	dd	Nampa-pt's choice	
9/2/2015	Sword	Ralph		S-1		Bryan	Thornton	III, MD	9/9/2015	AP	True Blue	dd	JRS/JRS	

Weekly New Patient Tracker

This wonderful tool is compiled by our New Patient Assistant, who seats our new patients and is in the room with them when the doctor sees them. She keeps track on this form what happened with each patient during their first appointment to our office. As you can see the form tracks:

- Date of appointment
- First and Last name of the patient
- Whether or not the patient got study models (SM)
- The outcome of the appointment (in this case the type of appliance prescribed — if a patient had been referred for a sleep study or something else it would have stated what the patient was being referred for)
- If the patient was being referred, to whom they were being referred
- When they were scheduled for their fitting appointment, or why they chose not to schedule yet
- Any pertinent notes about the patient

Down in the bottom left corner our office totals this form. Because we use this form for our TMJ patients as well, we have 2 columns of totals (1 for TMJ patients (TMD) and one for our sleep patients (SDX)) and a combined column. You may not need all those columns—for your office you may just have a “TOTALS” column with the item you are totaling and the numbers column. In our Totals Column we track:

- Number of sleep & TMD patients we saw for the week (Patients)
- Number of patients we referred for Sleep Studies (SS Referral)
- Number of patients we referred to physical therapy (PT Referrals, these are mainly for our TMJ patients)
- Number of patients we gave home instructions to (Home Tx— mainly our TMJ patients)
- Number of patients that entered treatment (Entered Tx)

At the end of each week the New Patient Assistant sends this form to our Doctors, Office Manager, and Insurance specialist so they can keep track of how we're doing and what needs to be done with each of our patients.

DATE	Last Name	First Name	SM	Outcome	Referred To:	Scheduled	Why Not Scheduled	Meeting Notes
3/9/2015			Y	EMA		3/16/2015		impressions taken, fitting sched
3/9/2015			Y	EMA		3/16/2015		impressions taken, fitting sched
3/9/2015			Y	EMA		3/11/2015		impressions taken, fitting sched
3/9/2015			Y	Herbst				impressions taken, sent to lab
3/9/2015			N	Herbst			Finances	pt had AARP didn't want to move forward yet
3/10/2015			Y	Herbst				impressions taken, sent to lab
3/10/2015			N	Herbst			Finances	problems w/ins that RMM is working out
3/10/2015			Y	EMA		3/16/2015		impressions taken, fitting sched
3/10/2015			Y	EMA		3/17/2015		impressions taken, fitting sched
3/11/2015			N	Somnomed, pT				pt has current appliance, needed adj, he moved here from CA
3/11/2015			Y	EMA			Needs Pre-auth	impressions taken, waiting for auth
3/11/2015			Y	EMA		3/18/2015		impressions taken, fitting sched
TOTALS	TMD	SDX	ALL					
Patients	5	12	17					
SS Referral	0	0	0					
PT Referral	1	1	2					
Home Tx	0	0	0					
Entered Tx	2	9	11					

Insurance Website Password Spreadsheet

It's a good idea to keep a spreadsheet of your usernames and passwords for each insurance company. If you prefer to make a blank one and then write everything down (so it's not on your computer) that's another option. Just as long as several people know where it is in case you're gone and someone needs to work with an insurance company. After working with insurance companies for years, our list is pages and pages long!

Payor Name	Username	Password	Hint:	Phone #	Website
AARP				877-842-3210	Use UHC website
AARP Gap Exception				800-537-2977	
AARP Supplement F				800-227-7789	
Aetna				888-632-3862	Prior auth fax 860-975-3234 Website is via Navinet
Aetna Senior Sup Ins					Pizza, Cindy
Aetna				859-455-8650	Courtesy predetermination fax number
Navinet/Aetna					
Aim - BC Sleep				866-714-1103	
AIM BC Imaging				866-714-1105	
AIM-Regence				877-291-0509	
AIM-Pacific Source			Weiser	877.291.0510	https://www.providerportal.com/Default.aspx
Alaska Medicaid					associated ph#208-514-4735, contact name Rose Mary
Altius				800-377-4161	
AmeriBen				800.786.7930	https://secure.healthx.com/publicservice/loginv1/login.a
Ameriben			Cowboys	800-786-7930	800-821-6136 Harley, Rupert, Rupert
AmeriBen St Lukes			St Lukes	866-847-9547	
Anthem BC					Cindy
Availity-REGENCE					

Appendix C-How to Read a Sleep Study

Sleep study reports come in a lot of variety. Some reports will be “just the facts.” Others will have TONS of data. Here are the things that are important for us to review as dentists, and what we should point out to our patients.

Is it an in lab test, a home sleep test, or are you looking at the CPAP titration?

The first thing you need to determine is what type of study report you are looking at. You want to be looking at a baseline study, not the CPAP (continuous positive airway pressure) titration. Here are the different types of studies:

1. In lab polysomnogram, or PSG. This is the gold standard test and is performed with the patient going to a sleep lab, getting wired up, and spending the night in the lab while a technician attends the study.
2. A “home sleep test” or “out of center sleep test” (OCST). These are small devices that are usually sent home with the patient or sometimes mailed to them. They usually consist of a pulse-oximeter, 1 or 2 strain gauges, and a nasal cannula. Some home test units can also measure brain waves or have another means to determine if the patient is actually asleep or not (most home units only assume the patient is asleep...making them less accurate).
3. A “split night study.” This is an in lab PSG where the first part of the night is the diagnostic phase, and then, IF the patient shows significant sleep apnea, the patient is awoken and placed on CPAP. The rest of the night is used to find the optimal CPAP pressure to treat the sleep apnea.
4. CPAP titration study. This is an in lab PSG where the entire night is used to adjust the CPAP. Usually in these reports there will be an initial sentence about what the baseline PSG showed.

Once you know that you are looking at the baseline PSG or OCST, here are the things you want to look for:

1. AHI: What was the overall Apnea/Hypopnea Index (AHI)? The AHI is the measure of how bad the patient’s sleep apnea is. The scale of AHI is:
 - < 5 = normal (in an adult. In a child > 1.5 indicates clinically significant sleep apnea)
 - 5-15 = mild
 - 15-30 = moderate
 - >30 = severe

Now, let's take this AHI number and break it down a bit. Obstructive apneas and central apneas are added together to get the "A" in the AHI. Central sleep apnea is where the brain doesn't tell the person to try to breathe. [As a brief note, pure central sleep apnea is very, very rare, BUT if you ever see a patient with a high percentage of central sleep apnea, instead of obstructive, you will want to review the goals of oral appliance therapy with their physician, as oral appliance therapy typically will not affect central sleep apnea—neither does CPAP.] Hypopneas are the "H." A hypopnea is a reduction in ventilation by at least 50% that also results in a decrease of the O₂ saturation by 4% or more. In other words, a hypopnea is shallow breathing that results in desaturation. These are usually obstructive in nature, like partly kinking a hose, but not completely blocking the flow.

I enjoy showing the patient the difference between an apnea and a hypopnea by drawing on the back of one of the forms. I say, "in the sleep lab, or in your home study, you had a nasal cannula in your nose. Normally when you see these things they are to give someone extra oxygen. In this case, the cannula was measuring your breathing in and out. On the computer screen it would look like this:

I'll tell the patient that this, an apnea, happened "X number of times" throughout the whole night. This number will usually, but not always, be in the report. This is not the "index" but the actual number of obstructive and central apneas that occurred throughout the night. If the number of apneas is not specified in the report, then you can't show this.

I will then show the patient what a hypopnea would look like on the computer screen in the sleep lab:

I'll tell the patient that this, a hypopnea, occurred "X number of times" throughout the whole night.

By showing the patient the difference between an apnea and a hypopnea, it helps them to understand their problem better, and makes the severity of their sleep apnea make more sense...because the AHI does not tell the whole story.

Speaking of story, here's a little mathematical story problem for you:

Patient A's study shows that he had 60 obstructive apneas throughout the night. He had 30 hypopneas throughout the night. He slept 6 hours total. Therefore his AHI is $(60 + 30) / 6 = 15$.

Patient B's study shows that he had 30 obstructive apneas throughout the night. He had 60 hypopneas throughout the night. He slept 6 hours total. Therefore his AHI is $(30 + 60) / 6 = 15$.

Wait a second! They both have an AHI of 15 even though one had half as many actually episodes of stopping breathing? Yep!

Now let's take this to the extreme. What is the AHI if the patient had 120 apneas for the night, 0 hypopneas for the night, and slept 6 hours? $(120 + 0) / 6 = 20$.

What is the AHI if the patient had 0 apneas for the night (literally NEVER stopped breathing), 180 hypopneas for the night, and slept 6 hours? $(0 + 180) / 6 = 30$.

What? So BOTH of these patients have "severe sleep apnea," even though the second one NEVER stopped breathing?! That's correct.

So why do we care? I believe it is important to show the patient what is going on with them so that they better understand their problem. If you are told that you have severe sleep apnea and that you stop breathing 30 times per hour, but your wife of 20 years says that she has only rarely noticed you stopped breathing, are you going to believe the report? Probably not. So it is important to explain to the patient that even though they have been told that they “stop breathing X times per hour” (which is what they will think the AHI is) that they don’t actually completely stop breathing all of those times (unless of course they have 0 hypopneas throughout the night).

It’s also important for us to look at this as I believe, through experience, that we tend to have an easier time treating patients with more hypopneas than apneas. That doesn’t mean that we don’t treat people with lots of apneas, but it just means that we might “lower their expectations” a little of oral appliance therapy completely resolving their apneas.

2. Sleep Position: In conjunction with the AHI you will also usually find information about sleep position and the AHI when the patient is sleeping supine versus on their side. For most people their obstructive sleep apnea is worse on their back (supine). For some people you will notice that their problem almost exclusively occurs when they sleep supine. When you notice this, you should talk to the patient about this fact and encourage them to sleep as much as possible on their side, including once they get their oral appliance.
3. O2 Saturation: What is the O2 saturation nadir (lowest point), and how much time did the patient spend with an O2 saturation below 90%?

This is a pretty obvious one to us as to why it is important. However, most patients will not realize what the O2 saturation means. Explain to them that our blood O2 levels, at this elevation, should be above 95% most of the time. Explain that if they were in a hospital and their O2 level went below 90, alarms would go off! Then tell them that their O2 level dropped to a low of X and was below 90 X% of the night.

4. Sleep Stages: How much time the patient spent in the different levels of sleep during the study. Non REM sleep stages are referred to as N1, N2 and N3. Here are the “ideal” percentages:
 - N 1 is “light sleep” or “transitional sleep.” This should only account for about 5-10% of the total sleep time.
 - N2 is “restful sleep.” This should be about 45-55% of the total sleep time. When people have reduced deep sleep and REM sleep, they usually have increased N1 and N2 sleep.
 - N3 is “deep sleep” or “slow wave sleep.” This should be about 10-20% (much more in children, and becomes less as we get older).
 - REM is Rapid Eye Movement sleep, or “dream sleep.” We should have about 20-25% of our sleep be REM sleep. In REM sleep the muscles have much less tone (some will say paralyzed), and as such obstructive sleep apnea tends to be worse in REM sleep.

While there are a lot of things that are fascinating about how sleep works, here are the simple things you need to know and share with your patients.

First, if they have reduced deep sleep (N3) they will feel physically tired. They may also have muscle pain, or even “fibromyalgia” type symptoms.

Second, if they have reduced REM sleep they will feel mentally tired. They may also have memory problems and a “clouded intellect.”

For some of our patients you will be the first one to go over the baseline sleep study with them. For many of our patients it was months or years ago that their doctor reviewed their sleep study with them, so they have likely forgotten much of the information. Going over this information with the patient will help them, and you, to understand their problem much better and make them, in my opinion, more likely to stick with treatment.

Each sleep lab and sleep doctor will present their data a little different, but you should be able to find the above information in all sleep studies and help the patient to understand it.

We **do not** base our appliance selection on any of this information. ALL oral appliances work the same way...they keep the mandible from falling back, or keep it slightly forward. The data WILL help us to know how bad the patient’s obstructive sleep apnea is so that we will better know how to treat them and how important it will be for them to return to their physician for objective follow up and adjustment of the oral appliance in the sleep lab.

Follow Up Sleep Study:

I believe that ALL patients should be referred back to the referring physician (the one who wrote the prescription for the oral appliance) for consideration of a follow up sleep study with the oral appliance in place. IF the physician does decide to have a follow up sleep study, I also believe that it is ideal to have the appliance adjusted in the sleep lab by the sleep techs (you will normally need to teach them how to do this and have written protocols for this).

When comparing a baseline study to a follow up study, make sure that you compare apples to apples, and look for:

- PSG to a PSG is apples to apples, but
 - How long has it been since the last PSG?
 - Were both studies at the same lab?
 - Were both studies read by the same doctor?
- PSG to HST, or HST to PSG = not apples to apples = tough to make conclusions
- HST to HST may be apples to apples, but
 - How long since the last HST?
 - Is the same HST device being used (if not, probably not apples to apples)?

Once you understand the differences between the technical aspects of the baseline study versus the follow up study, look for the following things that may be different from the baseline study to the follow up study:

- How long has it been since the baseline study? Sleep apnea usually gets worse as we get older.
- Has there been any weight gain? Sleep apnea usually gets worse with weight gain.
- Different sleep posture? Sleep apnea is usually worse in the supine position.

- Look at more than just the AHI
 - Was there a change in the number of apneas?
 - Was there a change in the number of hypopneas?
 - Was there a change in the average O2 saturation? The nadir?

I have had several patients that prior to me referring them back to the physician for consideration of a follow up sleep study with adjustment of the appliance in the sleep lab, the patient reported feeling fantastic and having a major improvement of their snoring. However, when they went in for the follow up sleep study the report came back that they didn't do as well as I would have liked. In almost all of these cases I was able to compare the baseline study to the follow up study and find the reasons that we didn't see a big change in the AHI, even though the patient felt much better. The most common things I've seen that made the follow up study numbers not as good as I would have liked were:

- It had been 5 or more years since the baseline study.
- The patient had gained significant weight.
- The patient slept mostly non-supine on their baseline study, and mostly on their back on their follow up study.

The bottom-line is that it is important for us as dentists to understand what is presented in sleep study reports AND when follow up studies are completed to make sure that we compare the follow up study to the baseline study, and make sure that our objective data appears to be consistent with the subjective data of what the patient is reporting to us.

What to look for on a Sleep Study:

- Total sleep time (TST) and sleep efficiency (TST/total recording time = efficiency)
- Sleep stages (within normal ranges)
 - N1 = 5%
 - N2 = 50-55%
 - N3 (formally known as stage 3 and 4) = 10-20% (less N3 as we get older)
 - REM = 20-25%
- Ventilation summary
 - Obstructive Apneas
 - Central Apneas
 - Obstructive Hypopneas
 - Apnea/Hypopnea Index (AHI)
 - Respiratory Disturbance Index (RDI)
- Positional and REM data
 - Apneas, hypopneas, AHI (and maybe RDI) in
 - » Supine
 - » Lateral
 - » REM
 - » Supine REM
- Oxygenation
 - Lowest saturation (nadir)
 - Time below 90%

- Heart rate
- Limb Movements
- Sleep Doctor's "impression" and recommendations

Comparing one sleep study to another:

- Compare apples to apples
 - PSG to a PSG
 - » How long since the last PSG?
 - » Same lab?
 - » Same reading doctor?
 - PSG to HST, or HST to PSG—not apples to apples = tough to make conclusions
 - HST to HST
 - » How long since the last HST?
 - » Same device?
- Was anything different from the last study (baseline) to this study?
 - Weight gain?
 - Different sleep posture?
 - Different recording/sleep time?
 - Look at more than just the AHI
 - » Change in apneas?
 - » Hypopneas?
 - » O₂ saturation?

Are you an honest, good-hearted dentist (or do you work with one)?

Are you looking to help more of your patients by helping make oral appliance therapy more affordable?

If you answered “yes” to both those questions then you’re in the right place! Working with medical insurance will significantly increase the number of your patients that you are able to help.

In our practice:

- Many of our patients pay little (and sometimes nothing!) out of pocket for their care,
- The insurance companies refer patients to us,
- We are respected in our local medical and dental communities, and
- We spend very little money on external marketing.

We want these things for you too!

This book will get you started off on the right foot by helping you understand the complex world of medical insurance billing. From applying for an NPI number to figuring out how to use an ABN properly, we’ll lead you down the right insurance roads.

We know you want to help more of your patients and working with medical insurance is a great way to do that. So, whether you’re looking to hire an ethical insurance billing company (which is unfortunately not as simple as you’d think) or wanting to go it alone, your path starts here with this easy, step-by-step guide to revealing the mystery behind the sometimes frustrating game of medical insurance.

Let us begin...

