Dental Sleep Medicine
The Patient and Physician Friendly Practice

Insurance from “A to Pay”
Dental Sleep Medicine

THE PATIENT AND PHYSICIAN FRIENDLY PRACTICE

I STOLE AND EDITED THIS FROM MARTY LIPSEY
(MY INSURANCE GURU)
A = Assignment of Benefits

A procedure whereby a patient authorizes the administrator of the program to forward payment for a covered procedure directly to the treating healthcare professional (Field #13 on the CMS 1500).

Not all insurance companies allow AOB
Billing

Don’t Stand Out Like a Sore Thumb!

Bill Electronically

Dental vs. Medical Electronic Billing
The CMS-1500 is the standard claim form used by physicians and suppliers for claim billing. Although it was developed by The Centers for Medicare and Medicaid (CMS), it has become the standard form used by all insurance carriers.
<table>
<thead>
<tr>
<th>1. A. PATIENT NAME (Last Name, First Name, Middle Initial)</th>
<th>B. PATIENT SOCIAL SECURITY NUMBER</th>
<th>C. PATIENT DOB (MM DD YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. PATIENT ADDRESS (No., Street)</td>
<td>D. PATIENT CITY, STATE, ZIP CODE</td>
<td>E. PATIENT PHONE NUMBER</td>
</tr>
<tr>
<td>3. OTHER PATIENT NAME (Last Name, First Name, Middle Initial)</td>
<td>F. OTHER PATIENT SOCIAL SECURITY NUMBER</td>
<td>G. OTHER PATIENT DOB (MM DD YY)</td>
</tr>
<tr>
<td>4. PATIENT RELATIONSHIP TO INSURED</td>
<td>H. EMPLOYER NAME OR SCHOOL NAME</td>
<td>I. EMPLOYER PHONE NUMBER</td>
</tr>
<tr>
<td>5. PATIENT RELATIONSHIP TO INSURED</td>
<td>J. OTHER ACCIDENT? ( \text{YES} / \text{NO} )</td>
<td>K. PATIENT EMPLOYMENT? ( \text{YES} / \text{NO} )</td>
</tr>
<tr>
<td>6. MEDICAID RESUBMISSION</td>
<td>L. MEDICAID RESUBMISSION</td>
<td>M. MEDICAID RESUBMISSION</td>
</tr>
<tr>
<td>7. INSURED</td>
<td>N. INSURED RELATIONSHIP TO INSURED</td>
<td>O. INSURED DOB (MM DD YY)</td>
</tr>
<tr>
<td>8. INSURED RELATIONSHIP TO INSURED</td>
<td>P. INSURED EMPLOYMENT? ( \text{YES} / \text{NO} )</td>
<td>Q. INSURED EMPLOYER NAME OR SCHOOL NAME</td>
</tr>
<tr>
<td>9. OTHER INSURED</td>
<td>R. OTHER INSURED RELATIONSHIP TO INSURED</td>
<td>S. OTHER INSURED DOB (MM DD YY)</td>
</tr>
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<td>10. PATIENT EMPLOYMENT? ( \text{YES} / \text{NO} )</td>
<td>T. PATIENT EMPLOYER NAME OR SCHOOL NAME</td>
<td>U. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>11. PATIENT EMPLOYER NAME OR SCHOOL NAME</td>
<td>V. PATIENT EMPLOYER PHONE NUMBER</td>
<td>W. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>12. PATIENT EMPLOYER NAME OR SCHOOL NAME</td>
<td>X. PATIENT EMPLOYER PHONE NUMBER</td>
<td>Y. PATIENT EMPLOYER PHONE NUMBER</td>
</tr>
<tr>
<td>13. PATIENT EMPLOYER NAME OR SCHOOL NAME</td>
<td>Z. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AA. PATIENT EMPLOYER PHONE NUMBER</td>
</tr>
<tr>
<td>14. DATE OF CURRENT: MM DD YY</td>
<td>AB. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AC. PATIENT EMPLOYER PHONE NUMBER</td>
</tr>
<tr>
<td>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. MM DD YY</td>
<td>AD. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AE. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>AF. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AG. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>AH. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AI. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY</td>
<td>AJ. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AK. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>19. RESERVED FOR LOCAL USE</td>
<td>AL. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AM. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>20. OUTSIDE LAB? ( \text{YES} / \text{NO} )</td>
<td>AN. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AO. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</td>
<td>AP. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AQ. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>22. MEDICAID RESUBMISSION CODE</td>
<td>AR. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AS. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>23. PREMATURE MORTALITY REPORT</td>
<td>AT. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AU. PATIENT EMPLOYER PHONE NUMBER</td>
</tr>
<tr>
<td>24. ENCOUNTER INFORMATION</td>
<td>AV. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AW. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>25. FEDERAL TAX I.D. NUMBER</td>
<td>AX. PATIENT EMPLOYER PHONE NUMBER</td>
<td>AY. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>26. PATIENT ACCOUNT NO.</td>
<td>AZ. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BA. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>27. BILLING PROVIDER INFO &amp; PH #</td>
<td>BB. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BC. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>28. TOTAL CHARGE $</td>
<td>BD. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BE. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>29. AMOUNT PAID $</td>
<td>BF. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BG. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>30. BALANCE DUE $</td>
<td>BH. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BI. PATIENT EMPLOYER PHONE NUMBER</td>
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<td>31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS)</td>
<td>BJ. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BK. PATIENT EMPLOYER PHONE NUMBER</td>
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<td>32. SERVICE FACILITY LOCATION INFORMATION</td>
<td>BL. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BM. PATIENT EMPLOYER PHONE NUMBER</td>
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<tr>
<td>33. BILLING PROVIDER INFO &amp; PH #</td>
<td>BN. PATIENT EMPLOYER PHONE NUMBER</td>
<td>BO. PATIENT EMPLOYER PHONE NUMBER</td>
</tr>
</tbody>
</table>

**CPT Code**


**ICD 9 Code**

“International Classification of Diseases”

**Diagnosis Pointers:**

How these are paired
CPT Codes

CPT or *Current Procedural Terminology* codes are developed, maintained and copyrighted by the AMA (American Medical Association.) As the practice of health care changes, new codes are developed for new services, current codes may be revised, and old, unused codes are discarded. Thousands of codes are in use, and they are updated annually.
Deductibles

Should be at the top of the list when calling medical insurance

Difference in Dental vs. Medical
You are no longer solely a provider, you are now a supplier of Durable Medical Equipment
E = E & M

Evaluation and Management

E/M = Cognitive Labor
E/M Coding is how patient encounters are translated into 5 digit numbers to facilitate billing

Does Not Exist in the Dental World
### Key Components

<table>
<thead>
<tr>
<th>History</th>
<th>HPI</th>
<th>PFSH</th>
<th>ROS</th>
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<tbody>
<tr>
<td>PF</td>
<td>Brief</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>EPF</td>
<td>Brief</td>
<td>None</td>
<td>1</td>
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<tr>
<td>Detailed</td>
<td>Ext</td>
<td>1 of 3</td>
<td>2 - 9</td>
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<tr>
<td>Comp</td>
<td>Ext</td>
<td>3 of 3</td>
<td>10</td>
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</table>

<table>
<thead>
<tr>
<th>Exam</th>
<th>Bullets</th>
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<tr>
<td>PF</td>
<td>1 - 5</td>
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<tr>
<td>EPF</td>
<td>6 - 11</td>
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<tr>
<td>Detailed</td>
<td>12</td>
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<tr>
<td>Comp</td>
<td>2 bullets from NINE systems</td>
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<table>
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<th>MDM</th>
<th>Prob Pts</th>
<th>Data Pts</th>
<th>Risk</th>
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<tbody>
<tr>
<td>SF</td>
<td>≤ 1</td>
<td>≤ 1</td>
<td>Min</td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>2</td>
<td>Low</td>
</tr>
<tr>
<td>Mod</td>
<td>3</td>
<td>3</td>
<td>Mod</td>
</tr>
<tr>
<td>High</td>
<td>≥ 4</td>
<td>≥ 4</td>
<td>High</td>
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</table>

**Flow:**

1. **History**
2. **Exam**
3. **MDM**
If You Help Your Patients with Their Dental Insurance

Why Not Help Them with Their Medical Insurance?

What would you like or expect if you were the patient?
MEDICAL BILLING
Hire Medical Billing Company That Knows “Sleep” OR Do it yourself “electronically”
Golden Trilogy of Documents

- **Must Have:**
  - **COPY OF SLEEP STUDY**
    - Diagnosis of Obstructive Sleep Apnea (ICD-9 Code 327.23) from a sleep test (Embletta or PSG) diagnosed by a board certified sleep physician
  
- **Letter of Medical Necessity**
  - for an oral appliance – signed by the physician (this is essentially a prescription for the appliance).
  - This can come from the diagnosing physician or the primary care physician.

- **Documented CPAP intolerance or non-compliance**
  - IF the patient has attempted CPAP first (this can be done with the affidavit of CPAP intolerance form)
## Codes & Fees ARE SIMPLE for a typical case

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Fee Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Brief History – Consultation</td>
<td>$50-$100</td>
</tr>
<tr>
<td>99212</td>
<td>Extended Office Visit – 20+ Minutes (Evaluation of Progress)</td>
<td>$100-$200</td>
</tr>
<tr>
<td>70355</td>
<td>Orthopantogram (Panorex)</td>
<td>$50-$100</td>
</tr>
<tr>
<td>92512</td>
<td>Nasal Function Study (Rhinometer)</td>
<td>$50-$100</td>
</tr>
<tr>
<td>92520</td>
<td>Laryngeal Function Study (Pharyngometer)</td>
<td>$50-$200</td>
</tr>
<tr>
<td>E0486</td>
<td>Custom Fabricated oral Appliance for sleep apena</td>
<td>$1800-$2,200</td>
</tr>
<tr>
<td>G0399 or 95806</td>
<td>Level III Home sleep study</td>
<td>$200-$350</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>$2,300 - $3,250</strong></td>
</tr>
</tbody>
</table>
STEPS FOR MEDICAL BILLING FOR SLEEP

**ONE-PREAUTHORIZE**

get Pre-Auth Number

- Call number on back of insurance card
- Get name and person’s “employee number”
- They will ask for three things to fax
  - Sleep study
  - CPAP intolerance form
  - MD Rx
- They might ask for more
  - Maybe Med History
  - Maybe Epworth
STEPS FOR MEDICAL BILLING FOR SLEEP
ONE-PREAUTHORIZE

- Someone will call you back
  - Give you authorization number
  - Ask for more information

- Once you have authorization you let patient know

- They will probably not tell you what they will pay
  - As you collect data you still might not know-as each plan within the ins. Company might be different

- So you now explain to patient
STEPS FOR MEDICAL BILLING FOR SLEEP

EXPLAIN TO PATIENT

• Deductible might not have been met
• Pre-authorization is no guarantee they’ll pay
• “Your part will be no more than.........”
  • Let them know the max as the “self pay” fee
• Do you have a flex plan?
STEPS FOR MEDICAL BILLING FOR SLEEP

BILL INSURANCE AT DELIVERY

- Send needed bill to insurance company and let them create electronic form
- Send electronically yourself
Enter into Lipsey Software
it will create electronic form to bill
or statement for billing company

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Diagnosis Description</th>
<th>Date of Visit</th>
<th>Time(s)</th>
<th>Service Count</th>
<th>Unit Price</th>
<th>Total</th>
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<tbody>
<tr>
<td>12/02/2011</td>
<td>5014.12 NASAL FUNCTION STUDIES</td>
<td>1:5:09</td>
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<td>$100</td>
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<td>12/04/2011</td>
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<td>1:0:00</td>
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<td>$350</td>
<td>$350.00</td>
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</tbody>
</table>

| Total Charges | $3800.00 |
| Total Paid | $300 |
| Balance Due | $3500.00 |
STEPS FOR MEDICAL BILLING FOR SLEEP

TRACK INSURANCE

- Wait for payment and track it
- If they ask for more you can give it to them
- Bill any balance to patient or refund if patient overpaid
YOU WILL RUN INTO THIS!!!!

- Insurance company says “you are out of network”
- Your appliance is medically unnecessary
“YOU ARE NOT IN NETWORK”

- Call company and get name and employee number
- Ask who is in Network
  - Often it will be an Oral Surgeon
  - Confirm they make oral appliances
    - If not – ask for “gap coverage”
    - If they do make oral appliances – “how far are they from the patient’s home geographically” (you would already know this from the internet) If too far away ask for gap coverage
    - If someone is in network and does appliances – you might want to join the network – up to you
“THE APPLIANCE IS MEDICALLY UNECESSARY

- Ask to speak to the M.D. consultant
  - There is probably something missing in the forms
    - Even a mistake like the AHI 7.8 when it was in the 70’s
  - MD might want more information
  - They do respond – (so far so good)
F = Fees

- How to establish fees
  - Ramifications of fees established by other dentists
- How to review fees with patients
- What does the fee include?
G = Guarantee

Medical vs. Dental

MMI
I = Intolerance

Affidavit/Certificate of CPAP Intolerance

One of the 3 baseline recommended documents to keep in every patient record
K = Key

The key to building a successful dental sleep medicine practice is to implement tried and true systems in a patient and physician friendly manner.
L = Learn the Lingo

Doctor + Team
M = Medicare

THE ELEVENTH COMMANDMENT
Thou Shalt Listen to Medicare
J = Jurisdiction
Medicare

• Came out with a code (E0486) in 2008 with detailed description for dental treatment of sleep apnea.

• Attached a $0 fee to that code

• Coverage until now has been sporadic.

• As of January 3, 2011 – regional LCDs have come out for E0486 and it is now being reimbursed.
  • Reimbursement varies by region ($850-$2000)
A custom fabricated mandibular advancement oral appliance (E0486) used to treat obstructive sleep apnea (OSA) is covered if criteria A – E 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 either of the following criteria (1 or 2):
   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.

C. If the AHI >30 or the RDI >30 and meets either of the following (1 or 2):
   1. The patient is not able to tolerate a positive airway pressure (PAP) device or
   2. The treating physician determines that the use of a PAP device is contraindicated.

D. 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.)
Medicare

• In order to be able to accept Medicare you must be a Medicare Part B AND and Medicare DME provider.

• You can only bill ONE code for treatment (E0486) and this code covers the appliance and all offices visits, tests, exams and follow-ups for 90 days.
Medicare: Pick 1

1. Opt-Out
2. Participating Provider
3. Non-Participating Provider
Medicare Opt-Out

- Relatively simple procedure to opt-out
- Opt-outs last 2 years and are renewable
- A Dentist MUST opt out of Medicare in order to charge a Medicare patient an out of pocket fee for a covered Medicare procedure.
- The fee you charge is not restricted and will not be reimbursed to you or to the patient
Medicare Participating Provider

- Must sign up to be a Medicare Part B and Medicare DME provider.
  - Lengthy application process
  - There are companies that will help you with this (for a fee)

- Assignment of payment goes to dentist.
- Providers must accept the Medicare fee schedule payment for the procedure
- Medicare pays 80%, patient pays 20%
- Medicare will forward claim to supplemental insurers “Medigap” for additional coverage.
Medicare: Non-Participating Provider

- Patient pays the fee out of pocket, Medicare assignment goes back to them.

- If you choose not to participate and do not accept assignment on claims, the maximum amount you are allowed to charge is 115% of the approved fee schedule amount for participating providers. The beneficiary is not responsible for billed amounts in excess of this limiting charge.
Must Have:

- Diagnosis of Obstructive Sleep Apnea (ICD-9 Code 327.23) from a sleep test (Embletta or PSG) diagnosed by a board certified sleep physician.

- Letter of Medical Necessity for an oral appliance – signed by the physician (this is essentially a prescription for the appliance).
  - This can come from the diagnosing physician or the primary care physician.

- Documented CPAP intolerance or non-compliance IF the patient has attempted CPAP first
  (this can be done with the affidavit of CPAP intolerance form)
FEE SCHEDULE AMOUNT ESTABLISHED FOR ORAL APPLIANCES FOR DIAGNOSIS OF OBSTRUCTIVE SLEEP APNEA

NAS has established a fee schedule amount for HCPCS code E0486 (Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment). Effective April 1, 2011, E0486 has a fee schedule amount of $1,175.39 for services provided in 2009 and 2010. The fee schedule amount for services in 2011 is $1,290.63.

As a DME MAC, we established a fee schedule amount based on the following gap filling criteria outlined by CMS:

- Contractors gather enough pricing information or processes enough claims to enable them to gap-fill a base fee.
- After the contractor has processed a minimum number of claims using an interim payment method, they must gap-fill base fees using the average allowed amount for the claims they have paid. A minimum number of claims required for establishing a fee are claims from at least four suppliers who have at least three charges each.

Posted on 04/26/11
What does Medicare Say?

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 AHI or 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 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).
There are two sets of codes used by Medicare and Medicaid. The first set, HCPCS Level I, are based on and identical to CPT codes, the codes developed by the American Medical Association. Level II HCPCS codes are used by medical suppliers other than physicians, such as ambulance services or durable medical equipment.
O = OA, OSA

- OA = E0486
- OSA = 327.23
The only products which may be billed using code E0486 are those products for which a written coding verification has been made by the PDAC Contractor.
Protocol

If you follow the proper Protocol

Then = Pay
Inevitably, Someone Will Ask

What about Q to Z?
Q = Quintessential
& Questions
Zzzzzzzzzzzz =