PREPARING YOUR TEAM TO TREAT SLEEP APNEA PATIENTS

How this Service Offering can Help Your Patients and Grow Your Business

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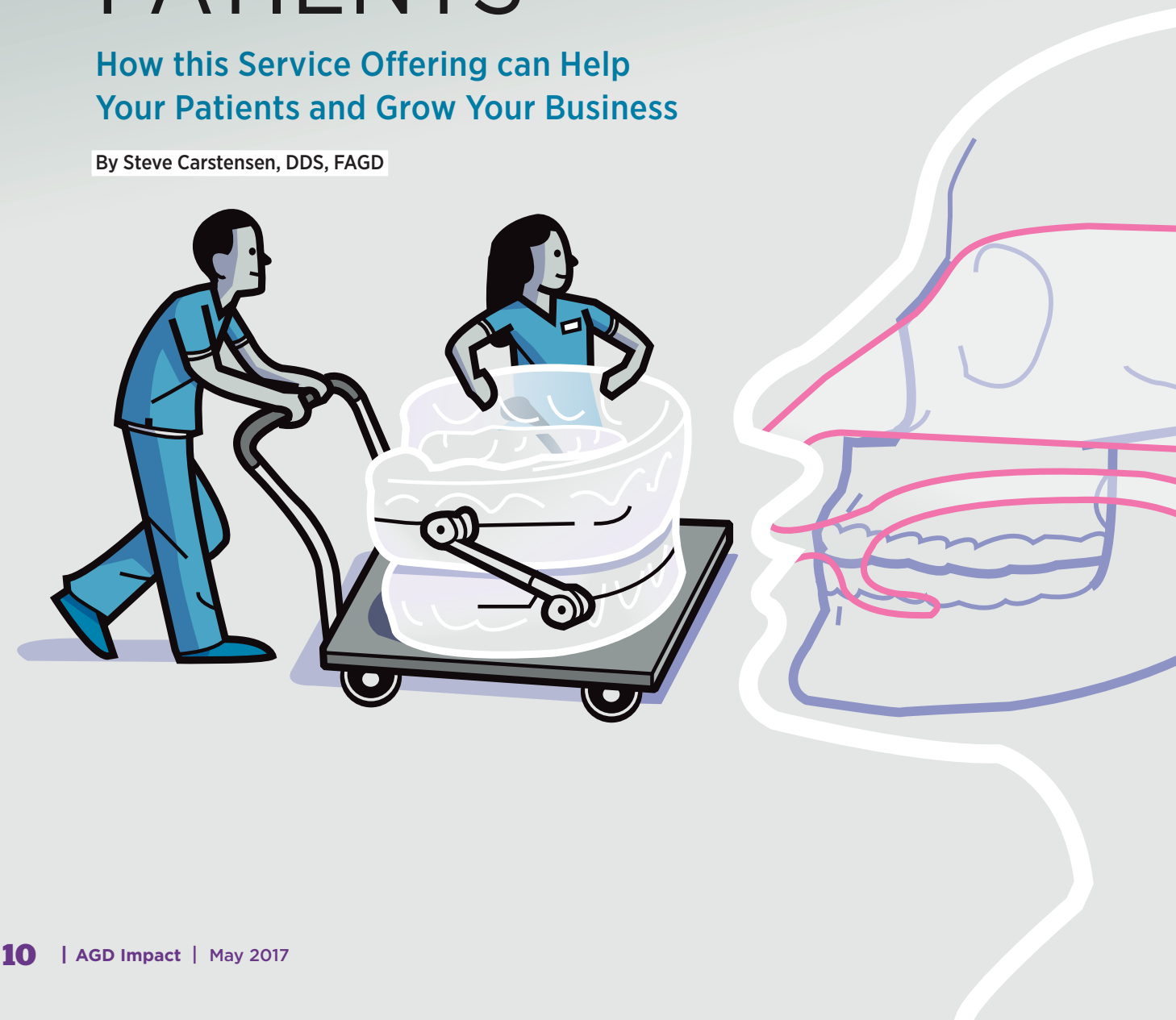

You've probably heard that treating snoring and sleep apnea patients is the "new thing in dentistry." You've also probably taken a sleep apnea class and heard how exciting, schedule-filling or lucrative it can be for your practice. Your restorative patient kind of falls asleep during the appointment; your night guard patient says she can't use the device because she chokes on it. The clues are piling up: You have patients with sleep breathing problems (such as snoring, pauses in breathing, etc.), and they need your help. (Spoiler alert: When you start taking notice of patients who present with these symptoms, you'll realize it's maybe 30 percent of your patient base!)

In the majority of practices, dental team members are performing the valuable functions that enable us as dentists to provide care for our patients. These highly trained professionals know what they are doing, enjoy their roles and, like every other human, are resistant to change. Because they don't know what you know, what you see as clues driving a new service may not even be visible to them.

EDUCATING THE DENTAL TEAM ABOUT SLEEP APNEA TREATMENT

Think about preparing your team to identify and treat sleep apnea in the same way you think about presenting a treatment plan. You have expertise that allows you to see impending doom in those unhealthy gums, wear facets, failing fillings, cracked teeth — all the pathology that is so apparent to us but invisible to our untrained patients. The most successful way to help them make a choice for health is to get them to ask for it. "Wow, Doc, what should I do about it?" Isn't that your favorite question? (OK, maybe, "Can I pay you now?" is slightly ahead.)

To successfully integrate a new service into your practice, such as treating sleep apnea patients, work to give your team a reason to ask, "How can we do this for our patients?" They want to be prepared, to be experts, to be confident that their patients are going to be well-served. Think about your own sleep education. You learned new terminology, the pathophysiology of sleep breathing disorders and the comorbidities that often accompany obstructed breathing. There were screening tools provided, and you know the path of a patient from discovery to diagnosis to treatment to follow up.

Being a participant and faculty member at The Pankey Institute has taught me that the best way to learn something is to teach it. Here's your chance! You've created a team of people who trust you, who share your values, who want to be part of not just a successful team, but your successful team. Once you know the devastating health problems that can be caused by obstructive sleep apnea (OSA), you'll never see your patients the same way. Do you really have a choice? Aren't you obligated to at least screen and refer? Will even starting to do that create the need for change in your practice?

As philosopher Alan Watts says, "The only way to make sense out of change is to plunge into it, move with it and join the dance."

One person on your team will emerge as your office's "sleep champion." He or she will find the learning fascinating, the service enthralling and the patient appreciation the most satisfying reward ever. This invaluable team member will become your best resource of ideas and strategies for helping every coworker see their role in sleep apnea identification and treatment. Your administrative staff will be taking phone calls and questions, exchanging medical records with physicians and navigating the financial aspects of a medical service, including medical billing. Your clinical staff will help you make

Sleep disorders, including sleep apnea, have become a significant health issue in the United States. It is estimated that 22 million Americans suffer from sleep apnea, with 80 percent of moderate and severe obstructive sleep apnea cases undiagnosed.

Source: American Sleep Apnea Association

medical encounter notes, take records for the lab and deliver mandibular advancement devices (MADs). Your hygiene staff will screen patients and notice important clinical signs of a disease they've not known to look for before.

Start with laying out a learning plan. Terminology, anatomy, pathophysiology, comorbidities and clinical signs can all be found in the resources from your sleep dentistry courses, magazines, books and online. Bring patient stories in to make them real for your team, such as the young patient with the history of heart disease, the sleep bruxer or the patient who complains of being banished from the bedroom by a spouse. These patients may have thought they were only telling life stories, not really understanding that you were hearing important medical clues. Make sure your team is prepared to react the next time they hear such a story.

Use the STOP-Bang sleep apnea screening questionnaire, which is easy to deliver, score and discuss. Eight questions can yield sensitivities over 90 percent for detecting OSA risk, with negative predictive value between 46 and 90 percent for mild to severe apnea, according to the *PLOS ONE* research article, "Validation of the STOP-Bang Questionnaire as a Screening Tool for Obstructive Sleep Apnea among Different Populations: A Systematic Review and Meta-Analysis."

When you identify patients who need sleep apnea treatment, you must know what to do then: Line up resources in your community. You'll need board-certified sleep physicians, otolaryngologists, pediatricians, orthodontists and primary-care physicians who all understand sleep disorders. Your team can make the calls to find out who is interested in collaborating with a dedicated "sleep dentist." Here's a clue: Call and ask if you can refer your patients to them for diagnosis, letting them know you are ready to treat should oral appliance therapy be indicated. Coach your patient to understand that your service should be one of the treatment choices he or she is given. Maybe it's not the right one for him or her, but the discussion should be had.

CHOOSING THE BEST DEVICE FOR YOUR PATIENT

Making sleep apnea devices, mostly MADs, is within the skill set of every dentist. Nearly all of the more than 100 U.S. Food and Drug Administration (FDA)-cleared MADs are common acrylic — the same acrylic we learned about in our first year of dental school. Even outliers, made from medical-grade nylon or cast metal, are no challenge. What we dentists need to understand is how to match one of the 100-plus choices to the individual patient. There are several basic designs with features unique to each one. Space doesn't permit discussion of every one, but some fundamental issues can be described.

Do you have a patient with wide arches and little buccal corridor space? Stay away from the Herbst oral appliance. Someone who is paying out-of-pocket and wants maximum value? There are nylon MADs without a predictable life span because so few have failed in more than 16 years of clinical service. Patient concerned about moving teeth? One MAD is CAM-milled from a block of acrylic for a perfect fit, like the best retainer or a crown. Does your patient have short, round teeth with very little retention? Don't choose a device that rigidly attaches upper and lower arches.

You can learn about the various MADs from the labs or manufacturers; thankfully, most of them are helpful professionals who understand there is no universal MAD. Because humans vary, we must have multiple choices. Pick a few, and pay attention to how they perform with your patients. Is the device comfortable? Do they use it every night? What do they like or dislike about the device? Your team can gather this important information and help you learn about the MADs you choose to provide.

Be careful when considering lab costs in your device choices, though. MADs are intended to last for many years, so sticking with a high-quality lab and a proven design is critical. You may feel you can get by with a lower lab bill and a less robust MAD, but no one wins when that one fails prematurely and your patient wonders why you are treating a life-threatening disease with a low-quality service. The delta between the lowest and highest lab cost is a few hundred dollars. Make a good business decision about your fees, and you won't need to consider lab cost when you are deciding which device is the best option for your patient. Fewer patient problems and visits, and less chair time to deal with problems, translate into big overhead savings for you.

WORKING WITH PHYSICIANS AND DENTAL LABS

When we expand our service offerings to include sleep medicine, our patients now carry our brand to their physicians. How do you want to be perceived by the doctors who refer to you? Ensure your patients say great things about how your office does things, and you'll get more referrals.

We need those referrals because of the nature of sleep medicine. Some dentists prefer to think of snoring as an isolated condition and rely on the patient's own diagnosis. The fact that snoring is one of the most common signs of sleep apnea means that the critical medical problem must be ruled out before the patient can be considered "snoring only." A white, asymptomatic, persistent lesion on the side of the tongue in a smoker would never be treated "as only an apthous ulcer" because the patient reported confidence that he didn't have cancer, would it?

Medical history and physical examination training differ greatly in medical and dental schools, leaving dentists unable to do a thorough history and physical examination (H&P) and unlicensed to treat disease we are not trained to diagnose. Our licensure limits dentists to treating areas of the head and neck related to the oral cavity, and the oropharynx is certainly included on that list. Under our licensure, scope of practice reflects individual training. While a general dentist is licensed to treat nearly every dental condition, it takes special training to, for example, place implants. Without training, implant surgery lies outside that dentist's scope of practice. Because OSA and snoring are documented to cause medical problems outside the head and neck, diagnosis and placement of this finding within the patient's complete medical assessment falls outside any general dentist's licensure. Treating the disease with MADs falls outside an untrained dentist's scope of practice. No regulation exists that defines "trained," but guidelines are being developed by the American Dental Association, and some voluntary standards have been published by the American Academy of Dental Sleep Medicine. Practicing outside your scope of practice or licensure will likely not be covered by your professional liability insurance.

What do you need, then, from the medical providers whom you will be working with? What do they do that we can't during that H&P? You can ask for their encounter notes and learn a great deal about your patients. Dr. Lindsey D. Pankey Sr. taught us that knowing your patients is one of the keys to a successful practice. While understanding their goals for treatment is what you talk with patients about, a careful

Learn More about Dental Sleep Medicine at AGD2017

At AGD2017, July 13–15 in Las Vegas, Steve Carstensen, DDS, FAGD, will present a comprehensive dental sleep medicine education track, broken up into two days of one-hour lectures. Courses in his one-hour lecture series include:

1. "Dental Sleep Medicine 2017 — What's New?"
2. "It's Good to Breathe Well at Any Age, All the Time"
3. "Talking about Sleepy Kids — How to Find Them, What to Say"
4. "Cardiovascular Consequences of Obstructed Airway Sleep"
5. "Non-Cardiac Medical Problems Associated with Obstructed Airway Sleep"
6. "Beyond Mandibular Advancement: Treating Airway Obstructed Sleep Differently"
7. "120+ Oral Appliances for Sleepy Patients? How to Choose!"
8. "Nothing's Free — Side Effects of Treating Obstructed Airway Sleep"
9. "Legal Issues Around Dental Therapy for a Medical Problem"
10. "Sleep Tests Are Snowflakes — How to Get the Info You Need"
11. "It's Not What You Do, It's What You Think About — Medical Encounter Notes"

To learn more about these courses and other educational offerings, visit *www.agd2017.org.*

CLINICAL PRACTICE GUIDELINE:

Sleep Dentists and Physicians Working Together

In a 2015 joint guideline from the American Academy of Sleep Medicine (AASM) and American Academy of Dental Sleep Medicine (AADSM), published in *Journal of Dental Sleep Medicine* and *Journal of Clinical Sleep Medicine,* oral appliance therapy is recommended for the treatment of adult patients with obstructive sleep apnea (OSA) who are intolerant of continuous positive airway pressure (CPAP) therapy or prefer alternate therapy. The guideline supports increased teamwork between dentists and physicians to achieve optimal treatment of patients with OSA. It comprises the following recommendations:

1. We recommend that sleep physicians prescribe oral appliances, rather than no therapy, for adult patients who request treatment of primary snoring (without OSA). (STANDARD)
2. When oral appliance therapy is prescribed by a sleep physician for an adult patient with OSA, we suggest that a qualified dentist use a custom, titratable appliance over non-custom oral devices. (GUIDELINE)
3. We recommend that sleep physicians consider prescription of oral appliances, rather than no treatment, for adult patients with OSA who are intolerant of CPAP therapy or prefer alternate therapy. (STANDARD)
4. We suggest that qualified dentists provide oversight, rather than no follow-up, of oral appliance therapy in adult patients with OSA, to survey for dental-related side effects or occlusal changes and reduce their incidence. (GUIDELINE)
5. We suggest that sleep physicians conduct follow-up sleep testing to improve or confirm treatment efficacy, rather than conduct follow-up without sleep testing, for patients fitted with oral appliances. (GUIDELINE)
6. We suggest that sleep physicians and qualified dentists instruct adult patients treated with oral appliances for OSA to return for periodic office visits, as opposed to no follow-up, with a qualified dentist and a sleep physician. (GUIDELINE)

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reading of a comprehensive H&P will enable you to help them attach observable symptoms to critical medical complications. Patients who present to the sleep physician are tested either in a sleep lab or at their homes to measure sleep breathing parameters and are diagnosed with OSA, upper airway resistance syndrome or "primary" snoring — all are sleep-related breathing disorders (SRBD). Since most people who are tested have demonstrable risk factors, a diagnosis of "snoring only" is rare. Some physicians, presented with a patient reporting snoring but having no other risk factors, have referred patients to me for snoring treatment, but, importantly, it was the medical doctor who made the call that there was not even enough risk of SRBD to do a test.

The FDA clears oral appliances to treat SRBD through an application and approval process. They are "Class 2 Medical Devices," a broad category that covers all sorts of things used to assist professionals in treating patients and requires a prescription by a medical doctor to provide to a patient and get paid. Interestingly, the FDA specifies it must be provided by a licensed dentist and manufactured in an FDA-licensed facility. The local lab you use for removable prosthetics might take a prescription for a MAD, have it made in such a facility and deliver it just like a removable partial denture. Or you might choose to send records directly to the sleep department of a major lab. The biggest value of developing a relationship with a dedicated sleep department is that you will benefit from the wisdom of lab artists who have created thousands of MADs and dealt with many problems. These lab partners are tremendous resources.

What does the lab expect from its dentist partners? Extremely accurate Vinyl Polysiloxane Impression Material (VPS) impressions or models, or a full-arch scan, will allow precision manufacturing of the device you prescribe. Ask your lab artist if your impressions are giving them what they need. Part of the FDA process gives them less leeway for modifying the device than other bespoke acrylic products. Along with the image of the arches, you'll be creating a 3-D bite to show where the mandible relates to the maxilla in the protrusive position you've chosen as a starting place. There are many ways to establish a starting place; most end up in a clinically sound, but random, spot. This is not a big concern if you are using an adjustable MAD. Technology will soon be available that will be able to predict whether a patient will be a responder to a MAD and where. Most important to the 3-D bite is making sure the lab professional knows exactly how to relate the arches. Working with your sleep lab artist will ensure this is a smooth process.

RECEIVING PAYMENT FOR SLEEP APNEA SERVICES

General dentists usually get paid for what they produce with their hands; e.g., tooth restorations, surgery and preventive services. Non-surgeon physicians get paid for evaluation and management, or E&M. Treating SRBD in a dental office is a hybrid. We are placing custom MADs but managing a chronic disease with potential side effects. There are two challenges related to this hybrid status: documenting what we are evaluating and managing and getting paid for our services.

Since SRBD is a medical problem with a physician diagnosis, there are no dental codes in the Code on Dental Procedures and Nomenclature (CDT) to cover services. Only medical insurance covers sleep therapy, from the exam to the imaging to the MAD itself. Coverage is guided by the principle of "medical necessity," which each payer can define for itself. Because SRBD is defined by objective data, these definitions are clear and almost universally available on the insurance company's website. Search there for "sleep apnea," and you'll find it. Most payers require a preauthorization of benefits, which is a way of testing whether you have obtained the required documentation of medical necessity for your patient. This is typically made up of a diagnosis, encounter notes from the H&P and a prescription for a MAD. Here's another tip: To comply with the Health Insurance Portability and Accountability Act (HIPAA), physicians and payers fax documents such as these. eFax is OK, but be sure it's secure.

The typical dental software does not provide a very good electronic health record. It's great at recording codes for what is done and providing information to dental insurance, but medical encounter documentation is more specific. E&M codes are defined differently from any dental codes and have narrow parameters that must be met. Many dentists are trained in SOAP (subjective, objective, assessment, plan) notes for initial encounters. Done well and thoroughly, SOAP notes are sufficient. It's better to learn the details of E&M coding and see how the dental team can fill in enough data to support the codes that are submitted. One great way to learn this is to study the reports that come to you from medical offices, where the process is done routinely every day. The E&M note format is designed to help the medical professional recall what was being reported, assessed and planned for. Medical decision-making is the most important part of being a doctor. You do this in your practice, but we don't have codes for it in dentistry. Our dental software is not set up for this format, but there are specialized software choices available just for dental sleep medicine.

Do you have to deal with medical insurance? Does it sound like a lot of work? I wish I could say "no" to that, but the medical professionals with whom you must interact and the patients we share all expect their insurance to be part of the equation. Cash-only certainly works, but you won't treat many patients. Thankfully, the industry has stepped up, and there are many medical billing companies ready to help you manage this process. You pay for their services, but your patients will be better served, and your team does not have to learn how to do medical billing with incapable software. Those specialized software packages often contain ways to submit medical billing directly using the encounter notes and the physician's notes you've uploaded. There is a growing field of dental sleep consultants who can help your whole team navigate these requirements.

Adding a new service such as sleep apnea treatment to a busy dental practice is a serious decision that must match your values, goals and office culture choices. It comes with a lot of work by the dentist, the "sleep champion" and every member of the dental team. Scheduling, patient flow and billing will all be impacted. Without careful planning, financial benefits may not materialize. Sound a bit scary? Yes. But have you ever seen great rewards come without risk or hard work? Rewards only come to those who stretch, take chances and discover that there are no limits to the impact they can have on their patients' lives. Do you feel great about your excellent dental services? Your patients love you for their beautiful new smiles? Think about how amazing it will feel when a patient thanks you for saving his or her life! ✦

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