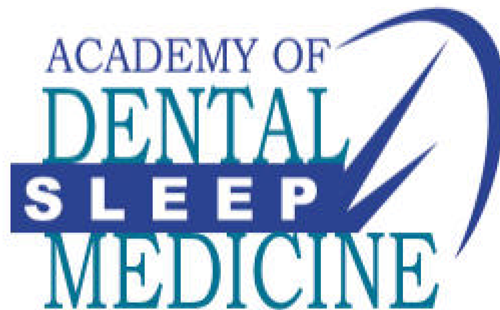
Academy of Dental Sleep Medicine

Guide to Insurance Reimbursement



Updated January, 2001

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INTRODUCTION

During the years since the founding of the Academy of Dental Sleep Medicine (formerly Sleep Disorders Dental Society) in 1991, the Reimbursement Committee has provided information to assist dentists in improving reimbursement for oral appliance therapy. The intent of this guidebook is to educate and instruct dentists and their administrative personnel about the most efficient and effective methods of attaining appropriate reimbursement from all insurance carriers. This information was compiled through numerous discussions with medical insurance personnel, dentists, and dental office personnel throughout the United States and Canada.

This booklet is meant to guide you in understanding the medical insurance system and to develop relationships with the insurance carriers in your region in order to enhance reimbursement for you and your patients. The information in this booklet is only a recommendation of the protocols, descriptions, and codings that may be used to improve reimbursement. However, it is recommended that you finalize this information with the individual insurance carriers. We have included three blank pages for notes at the back of this guidebook if you wish to maintain notes or records about the individual insurance carriers and their policies, codes and descriptions.

The ADSM Insurance Reimbursement Committee would appreciate any feedback or recommendations to update this guidebook in the future. If you have any suggestions or comments regarding this booklet, please contact:

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THE INFORMATION IN THIS GUIDEBOOK IS INTENDED AS GENERAL BACKGROUND INFORMATION ONLY. PRIOR TO IMPLEMENTING OR RELYING ON ANY ADVICE IN THIS GUIDEBOOK, YOU SHOULD CONSULT WITH YOUR LEGAL AND FINANCIAL ADVISORS.

WORKING WITH THE INSURANCE COMPANY

INSURANCE PAYOR SOURCES

There are three primary categories of insurance payors in the health care marketplace. These categories are:

A. Managed Care Plans in which the provider enters into an agreement to provide care for all eligible participants and accept the "plan's" fees for reimbursement.
B. Traditional Indemnity Plans in which the provider is paid by the patient, then the patient submits the claim to their insurance company (Indemnity Plan) and receives reimbursement directly from the company.
C. Governmental Plans (Medicare, etc.) in which the provider agrees to provide care for all eligible participants and accepts the plan's fees for reimbursement based on the provider's contract.

These different types of insurance payors implement plans that have advantages and disadvantages for the dentists. We will now explore the issues that dentists must evaluate prior to deciding whether to provide care for patients covered by these payors.

A. MANAGED CARE PLANS

Issues of Providership

Dentists have the opportunity to become preferred providers for specific Insurance Companies and Health Maintenance Organizations (HMOs). As many of you have experienced, there are advantages and disadvantages to being an in-network provider. The participating providers generally see an increased volume of patients, however, the insurance plan controls the maximum allowable reimbursement levels for the procedures that you provide. Therefore, you must be cautious in reviewing the contract with the insurance plan prior to signing. Currently many patients are getting coverage for oral appliance therapy, even if the dentist is a non-participating provider, so the advantages of being a provider may be limited.

Precautions about Providership

These are a few of the precautions that must be considered prior to becoming a provider for a managed-care plan:

- Carefully evaluate fee levels and expected write-offs for all procedures
- Be aware that there is a potential for changes in fee structure in the future [this is controlled by the insurance company]

- Check on the prior authorization process including the turnaround time for this authorization process
- Inquire about the reimbursement/coverage policy on oral appliance therapy
- Does the fee for oral appliance therapy include the initial evaluation and follow-up visits or can these office visits be billed separately
- What is their policy regarding the time period for payment of claims

Note: Be aware that insurance companies will hire outside telemarketing companies to contact dentists to enroll them as providers with these carriers, therefore, you may be talking with a telemarketing person rather than an employee of the insurance company when you are first contacted to become a provider.

Letter to Insurance Company Confirming Codes

If you are an in-network provider for a managed-care plan, it is recommended that you confirm the appropriate diagnosis and treatment codes in writing. This can be accomplished by sending a letter to the director of medical and utilization review, the director of medical policy, or the medical director of the insurance company. In this letter outline your current diagnosis and treatment codes and ask that the insurance company confirm that these are the appropriate codes to be used for submission of claims and documentation for your patients. Ask for a reply in writing so that you can maintain a "paper trail". This documentation could be extremely valuable in the future if there is a change in insurance company personnel, a change in fee levels, or a change in the codes.

Developing a Relationship with a Contact Person

It can be very valuable to develop a relationship with a contact person at the insurance company to assist you in resolving any difficulties with claims or other issues related to insurance reimbursement. However, it can be difficult to identify the appropriate contact person. It is recommended that the office or business manager monitor the written responses from the insurance company to identify the claim supervisors, medical policy or utilization review personnel, or medical directors of the insurance companies. This will allow you to develop a list of contact persons including their direct mailing address, department, direct phone, and fax numbers for each of the insurance carriers with whom you are working. In the future all correspondence should be addressed to that supervisor or contact person. It would also be beneficial to call these contact persons on the phone to develop a relationship when it is appropriate.

B. Indemnity Plans (Traditional insurance plan)

The Indemnity plan is an agreement between the patient and the insurance company to provide coverage for the patient based upon the stipulations in the policy. Therefore the patient is responsible for payment for the service provided by the dentist. The patient receives a statement from the dentist

for these services and the patient (or the dentist may be willing to submit the insurance claim for the patient) submits the claim to the insurance company. The care is provided on a fee-for-service basis.

C. GOVERNMENTAL PLANS

Medicare Policy Regarding Payment for Professional Dental Services Related to Oral Appliance Therapy for OSA

In certain instances Medicare may provide coverage for professional dental services including diagnostic testing and evaluation rendered in connection with obstructive sleep apnea. Also, in certain circumstances, Medicare may provide coverage for oral appliance therapy.

However, there are limitations on what Medicare will consider to be a covered service. Consultations and office visits may be covered and Medicare will typically reimburse for a single polysomnogram performed in connection with obstructive sleep apnea, however, other forms of testing (unattended home monitoring) will require pervasive medical evidence to justify the need for these tests or additional polysomnograms.

Medicare Reimbursement for Oral Appliance Therapy

Health Care Finance Administration (HCFA) has indicated that in certain circumstances oral appliance therapy used for the treatment of obstructive sleep apnea may be considered to be a Medicare covered service. Although whether and when Medicare will cover oral appliance therapy provided by a dentist is somewhat unclear. There are questions about coverage such as:

- How one documents medical necessity for oral appliance therapy.[1]
- Whether the dentist must first enroll as a DME supplier.
- Whether the Stark Law[2] precludes a dentist from selling the appliance to his patients.

<u>Accordingly we advise that you consult with your legal and billing advisors regarding the correct approach for your practice.</u>

Billing the Medicare Patient Directly

Because of the uncertainty surrounding Medicare reimbursement for OSA, some providers have attempted to avoid dealing with Medicare on this issue, and to instead bill the patient for the appliance and related services. If you do any Medicare business, either as a participating or non-participating provider, you will be limited in what you can bill to the patient. Because dental services are not generally covered by Medicare, some providers have elected to formally "opt-out" of the Medicare program, thereby, allowing them to bill the entire charge to the patient. A less radical approach to consider is to stay in the program, but to use an advanced beneficiary notice ("ABN"), where appropriate, to allow you to bill the patient for a service which ultimately proves not to be covered.

Participating vs. Non-participating

If you have entered into a written agreement with Medicare, agreeing to be a *participating provider,* you have committed to accept Medicare assignment for all services to Medicare beneficiaries (patients). This means that you bill Medicare and not the patient for the covered services, but may bill the patient for any allowable co-payment or deductible. If you have not signed such an agreement, and you have not opted out of the Medicare program, you are considered to be a *non-participating provider*[3] and may elect to bill the patient directly. However, non-participating providers are limited in what they can bill to the patient by the limiting charge (which is a fixed percentage over the amount determined under RBRVS). Non-participating providers are free to accept or decline assignment on a case-by-case basis. Even if assignment is not accepted, however, you are required to prepare and submit the patient's bill to Medicare without charge.

Private Contracts Between Physicians and Beneficiaries (Patients): Opting Out of the Medicare Program

You can elect to opt out of the Medicare program entirely. That is, providers and patients are permitted to enter into agreements specifying that the provider will not bill Medicare and the patient will personally pay (without assistance from Medicare) for Medicare-covered services provided by the provider. If you opt out, you cannot receive Medicare reimbursement for any item or service for a period of two years.

In order to opt out, you must enter into a private contract with the patient. The private contract must provide specified beneficiary protections. In addition, the provider must file an affidavit with Medicare regarding the decision to opt out. An example of the private contract can be found on page 29 - 31, and an example of the affidavit with Medicare can be found on page 32 - 35.

Advance Beneficiary Notices

Short of opting out, you can preserve the right to bill the patient in circumstances where you believe that an item or service is not a covered service by giving the beneficiary (patient) an advance beneficiary notice ("ABN"). An ABN is appropriate to use only where the service is sometimes a covered service, but you believe that it will not be covered in a particular instance[4]. The provider still has an obligation to file the claim with Medicare, but may collect the cost from the patient (without regard to any Medicare limitations on the amount of the charge) once Medicare denies the claim. Please check with your legal and billing advisors for additional guidance regarding the use of ABNs.

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[1]Medicare apparently requires a follow-up polysomnogram to document the effectiveness of the oral appliance, but may be unwilling to pay for this follow-up polysomnogram.

[2]The Stark Law is an anti-self-referral law, and essentially precludes a provider from ordering certain items, including DME, but excluding orthotics, for a patient, if the items are to be provided for the ordering provider, or by another provider with whom the ordering provider has certain financial relationships. If the appliance is DME, then the Stark Law would appear to preclude the dentist from both ordering and supplying the appliance; if the appliance if an orthotics, then the Stark Law should not be a problem.

[3]Participating providers will receive slightly higher reimbursement for services (approximately 5%) compared to reimbursement for non-participating providers.

[4]The intent is that the beneficiary be able to make an informed decision my knowing in advance that he or she will have to pay for this service out-of-pocket in the likely event that Medicare denies the service.

OFFICE PROTOCOLS FOR INSURANCE REIMBURSEMENT

PATIENT'S FINANCIAL RESPONSIBILITY

Many dental offices are set up to utilize direct payment from insurance companies. This is done as a service for the patients. However, it is important that the patient understand that the insurance policy is an arrangement between the patient and the insurance company. The patient must also understand that they are personally responsible for all charges incurred during the office visits.

Many offices have a letter of financial responsibility that the patient must sign prior to the start of treatment.

If the dentist is not a participating provider with the patient's insurance carrier, then the dentist may wish to require payment at the time of service.

PRE-TREATMENT DETERMINATION OF BENEFITS

Prior to starting treatment, the patient may wish to have a pre-treatment determination of benefits letter sent to the insurance company to document their insurance coverage in writing. Two samples of these letters have been included on pages 21 and 22.

In addition to the letter, the following information should also be included:

- Polysomnogram results confirming diagnosis of OSA
- Sleep medicine physician's office notes confirming the treatment plan
- The dentist's progress notes from the initial office visit
- A copy of research articles supporting use of oral appliance therapy for OSA (See list of recommended articles on pages 16 - 19)

Most insurance carriers will reply by fax or mail within 2-4 weeks, unless the case is sent to a medical reviewer for determination. Then it could be up to 8 weeks to receive a reply.

Note: Many medical insurance carriers require that patient's with moderate to severe OSA have a trial of nasal CPAP prior to considering any other treatment. Coverage for oral appliance therapy may be considered if the patient is intolerant of nasal CPAP. Some insurance carriers may not require a trial of nasal CPAP prior to authorizing coverage for oral appliance therapy if the patient has mild obstructive sleep apnea.

APPEALING A DENIAL OF BENEFITS

It is possible to reverse a denial of benefits for oral appliance therapy if the patient's policy does not specifically exclude oral appliance therapy. The appeal should be focused on the medical necessity of

oral appliance therapy for treatment of the patient's obstructive sleep apnea condition and the research supporting the effectiveness of this treatment. However, it is the patient's responsibility to appeal the denial of benefits. Therefore, it is recommended that the dentist offer to send the patient a sample appeal letter that they can customize and submit to the insurance carrier. It is also recommended that the patient include copies of:

- Polysomnogram results
- Sleep medicine physician's office notes and letters
- The dentist's progress notes
- The dentist's pre-treatment determination of benefits letter
- Research articles

A copy of the sample patient appeal letter is on page 28.

SUBMITTING CLAIMS

The medical procedure codes and supportive information included in this book will assist you in improving your reimbursement for the evaluation and treatment procedures that you provide for your patients. All codes are taken from the physicians' *Current Procedural Terminology* (CPT) which is a listing of medical procedures and services. In the CPT coding system, each procedure or service is identified with a five-digit code. Please note that all claims should be submitted to medical insurance carriers.

Codes and Accompanying Documentation

Situation 1:

If a pre-treatment determination of benefits has been received prior to treatment, then the medical insurance claim form (see sample on page 20 and a copy of the insurance authorization document are the only forms that should be necessary.

Situation 2:

If no pre-treatment determination of benefits was received prior to the start of treatment, then the following information must be submitted:

- Medical insurance claim form (see sample on page 20)
- Polysomnogram results confirming diagnosis of obstructive sleep apnea (see sample on pages 26 and 27)
- Sleep physician's office notes confirming diagnosis and treatment with oral appliance therapy (see sample on page 25)
- The dentist's progress notes from the initial office visit (see sample on page 24)
- A letter from the dentist supporting the treatment (see sample on page 23)

It is also suggested that you consider submitting the medical insurance claims by registered mail. This will provide the dental office with documentation that the claim was received by the insurance company. This will reduce any confusion if the claim has not yet been entered into the computer system at the insurance company.

PROCEDURE OR SERVICE PROVIDED

(Including Description)

Office Visit for Evaluation of a New Patient (Referred by Another Healthcare Provider):

Medical Procedure Codes (**CPT#**)	Description	Fee
99241	A problem-focused history and examination and straight-forward medical decision making (Physician/dentist spends 15 minutes face-to-face with the patient and/or family)	
99242	An expanded problem-focused history and examination and straight-forward medical decision making (Patient presenting with problems of low severity; physician/dentist spends 30 minutes face-to-face with the patient and/or family)	
99243	A detailed history and examination and medical decision making of low complexity (Patient presenting with problems of moderate severity; physician/dentist spends 40 minutes face-to-face with the patient and/or family)	
99244	A comprehensive history and examination and medical decision making of moderate complexity (Patient presenting with problems of moderate to high severity; physician/dentist spends 60 minutes face-to-face with the patient and/or family)	
99245	A comprehensive history and examination and medical decision making of high complexity (Patient presenting with problems of high severity; physician/dentist spends 75 minutes face-to-face with the patient and/or family)	

Office Visit for Evaluation of a New Patient (Self-referral):

99201	Brief history, examination and consultation (Patient presenting with problems of mild severity; physician/dentist spends 10 minutes face-to-face with the patient and/or family)	
99202	Limited history, examination and consultation (Patient presenting with problems of mild to moderate severity; physician/ dentist spends 20 minutes face-to-face with the patient and/or family)	
99203	Standard history, examination and consultation (Patient presenting with problems of moderate severity; physician/dentist spends 30 minutes face-to-face with the patient and/or family)	
99204	Comprehensive history, examination and consultation (Patient presenting with problems of moderate to high severity; physician/ dentist to spend 45 minutes face-to-face with the patient and/or family)	
99205	Comprehensive history, examination and consultation (Patient presenting with problems of moderate to high severity; physician/ dentist to spend 60 minutes face-to-face with the patient and/or family)	

Radiographs or Other Diagnostic Tests:

94762	Overnight Oximetry	
70320	Radiological exam, complete full mouth	
70350	Baseline cephalogram	
70351	Cephalogram with appliance in place	
70355	Orthopantogram (panorex)	
21079	Diagnostic study models	

Treatment Procedures:

99002-22	Airway Dilator Therapy Description: Oral appliance therapy that may involve either use of a mandibular advancement device or a tongue retaining device to maintain patency of the pharyngeal airway	

Note: Insurance carriers may require different codes for airway dilator therapy. These codes may include: HCPC Code # E1399

The other CPT code numbers that have been reported to be effective by dentists in specific regions of the country are not consistently effective in getting reimbursement. These CPT code numbers include: 21299, 21085, 21110, 42999, 94799. The CPT code number 99002-22 has had the most success for reimbursement and is recommended at this time.

Reevaluation and Management of an Established Patient:

99212	Brief Office Visit (Evaluation of progress; Physician/dentist spends 10 minutes face-to-face with patient and/or family)	
99213	Limited Office Visit (Evaluation of progress; Physician/dentist spends 15 minutes face-to-face with patient and/or family)	
99214	Intermediate Office Visit (Evaluation of progress; Physician/dentist spends 25 minutes face-to-face with patient and/or family)	
99215	Extended Office Visit (Evaluation of progress; Physician/dentist spends 40 minutes face-to-face with patient and/or family)	

MEDICAL DIAGNOSIS CODES FOR SLEEP DISORDER MEDICINE

Diagnosis Codes (**ICD-9**)	**Description**
780.53	Sleep Apnea (with hypersomnia) • Most commonly used code
780.52	Intrinsic sleep disorder NOS (upper airway resistance syndrome)
786.09	Primary Snoring
780.57	Sleep Apnea
780.51	Sleep Apnea (with insomnia)
780.54	Post-traumatic hypersomnia
306.8	Sleep Bruxism
729.1	Fibromyalgia or myofascial pain

SUPPLEMENTAL INFORMATION

RESEARCH ARTICLES TO SUPPORT ORAL APPLIANCE THERAPY FOR OBSTRUCTIVE SLEEP APNEA

(* Denotes articles that should be copied when further supportive documentation is necessary for insurance coverage.)

1. Robin, P: Glossoptosis due to atresia and hypotrophy of the mandible. Am J Dis Child 48:541-547, 1934.

2. Cartwright, R, Samelson, C: The effects of a non-surgical treatment for obstructive sleep apnea: the tongue retaining device. JAMA 248:705-709, 1982.

3. Cartwright, R: Predicting response to the tongue retaining device for sleep apnea syndrome. Arch Otolaryngol 111:385-388, 1985.

4. George, P: A modified functional appliance for treatment of obstructive sleep apnea. J Clin Orthod 21:171-175, 1987.

5. Cartwright, R, et al.: Toward a treatment logic for sleep apnea: the place of the tongue retaining device. Behav Res Ther 26:121-126, 1988.

6. Bonham, P, et al.: The effect of a modified functional appliance on obstructive sleep apnea. Am J Orthod Dentofac Orthop 94:384-392, 1988.

7. Clark, G, et al.: Dental appliances for the treatment of obstructive sleep apnea. JADA 118:611-619, 1989.

8. Schmidt-Nowara, W, et al.: Treatment of snoring and obstructive sleep apnea with a dental orthosis. Chest 99:1378-1385, 1991.

9. Cartwright, R, et al.: A comparative study of treatments for positional apnea. Sleep 14:546-552, 1991.

10. Nakazawa, Y, et al.: Treatment of sleep apnea with prosthetic mandibular advancement (PMA). Sleep 15:499-504, 1992.

11. Lyon, H, et al.: Treatment of snoring and obstructive sleep apnea. Compend Contin Educ Dent 13:417-420, 1992.

12. Clark, G, et al.: Effect of anterior mandibular position on obstructive sleep apnea. Am Rev Respir Dis 147:624-629, 1993.

13. Yosida, K, et al.: Prosthetic therapy for sleep apnea syndrome. J Prosthet Dent 72:296-302, 1994.

14. Eveloff, S, et al.: The efficacy of a Herbst mandibular advancement device in obstructive sleep apnea. Am J Respir Crit Care Med 149:905-909, 1994.

15. Parker, J: Snoring and obstructive sleep apnea: treatment with oral appliances. Northwest Dentistry 74:17-25, 1995.

*16. Schmidt-Nowara, W, Lowe, A, Wiegand, L, Cartwright, R, Perez-Guerra, F, Menn, S: Oral Appliances for the Treatment of Snoring and Sleep Apnea: A Review. *Sleep* 18(6):501-510, 1995.

*17. American Sleep Disorders Association Board of Directors: Practice Parameters for the Treatment of Snoring and Obstructive Sleep Apnea with Oral Appliances. *Sleep* (18)6:511-513, 1995.

18. Barsh, L: The responsibility of the dental profession in recognizing and treating sleep breathing disorders. Compend Contin Educ Dent 17:490-500, 1996.

*19. Menn, S, et al.: The mandibular repositioning device: role in treatment of obstructive sleep apnea. Sleep 19:794-800, 1996.

20. Ferguson, K, et al.: A randomized crossover study of an oral appliance versus nasal continuous positive airway pressure in the treatment of mild to moderate obstructive sleep apnea. Chest 109:1269-75, 1996.

21. Clark, G, et al.: A crossover study comparing the efficacy of continuous positive airway pressure with anterior mandibular positioning devices on patients with obstructive sleep apnea. Chest 109:1477-1483, 1996.

22. Rogers, R: Sleep disordered breathing - part 2: oral appliances. *In* Clark's Clinical Dentistry, Volume 1, Mosby-Yearbook, Inc., 1996.

23. Ono, T, et al.: The tongue retaining device and sleep state genioglossus muscle activity in patients with obstructive sleep apnea. Angl Orthod 66:273-279, 1996.

24. Hans, M, et al.: Comparison of two dental devices for treatment of obstructive sleep apnea syndrome (OSAS). Am J Orthod Dentofac Orthop 111:562-570, 1997.

25. Ferguson, K, et al.: A short-term controlled trial of an adjustable oral appliance for the treatment of mild to moderate sleep apnea. Thorax 52:362-368, 1997.

26. Cohen, R: Obstructive sleep apnea: oral appliance therapy and the severity of condition. Oral Surg Oral Med Oral Path 85:388-393, 1998.

27. Yoshida, K: Effects of a prosthetic appliance for the treatment of sleep apnea syndrome on masticatory and tongue muscle activity. J Prosthet Dent 79:537-544, 1998.

28. Millman, R, et al.: Oral appliances in the treatment of snoring and sleep apnea. Clin Chest Med 19:69-75, 1998.

29. Eckhart, J, Veis, R, Simmons, J, Kneisley, L, Marshall, M, Barsh, L, Thornton, W: Snoring and obstructive sleep apnea. J Cal Dent Assoc 26:556-623, 1998.

30. Millman, R, et al.: The efficacy of oral appliances in the treatment of persistent sleep apnea after uvulopalatopharyngoplasty. Chest 113:992-996, 1998.

31. Clark, G: Mandibular advancement devices and sleep disordered breathing. Sleep Med Rev 2:163-174, 1998.

32. Marklund, M, et al.: The effect of anterior mandibular positioning on apneas and sleep in patients with obstructive sleep apnea. Chest 113:707-713, 1998.

33. Parker, J, et al.: A prospective study evaluating the effectiveness of a mandibular repositioning appliance (PM Positioner) for the treatment of moderate obstructive sleep apnea. Sleep 22 (Suppl 1): S230-231, 1999.

34. Pellanda, A, et al.: The anterior mandibular positioning device for the treatment of obstructive sleep apnea syndrome: experience with the Serenox. Clin Otolaryngol 24:134-141, 1999.

35. Ivanhoe, J, et al.: Dental considerations in upper airway sleep disorders: a review of the literature. J Prosthet Dent 82:685-698, 1999.

36. Wilhelmsson, B, et al.: A prospective randomized study of a dental appliance compared with uvulopalatopharyngoplasty in the treatment of obstructive sleep apnea. Acta Otolaryngol 119:503-509, 1999.

*37. Pancer, J, et al.: Evaluation of variable mandibular advancement appliance for treatment of snoring and sleep apnea. Chest 116:1511-1518, 1999.

38. Bondemark, L: Does two years nocturnal treatment with a mandibular advancement splint in adult patients with snoring and OSAS cause a change in the posture of the mandible? Am J Orthod Dentofac Orthop 116:621-628, 1999.

*39. Schmidt-Nowara, W: Recent developments in oral appliance therapy of sleep disordered breathing. Sleep and Breathing 3:103-106, 1999.

40. Pantin, C, et al.: Dental side effects of an oral device to treat snoring and obstructive sleep apnea. Sleep 22:237-240, 1999.

41. Yoshida, K: Effects of a mandibular advancement device for the treatment of sleep apnea syndrome and snoring on respiratory function and sleep quality. J Cranio Pract 18:98-105, 2000.

42. Kathe, G, et al.: An oral elastic mandibular advancement device for obstructive sleep apnea. Am J Respir Crit Care Med 161:420-425, 2000.

*43. Lowe, A, et al.: Treatment, airway and compliance effects of a titratable oral appliance. Sleep 23 (Suppl 3): S1-7, 2000.

44. Lowe, A.: Oral appliances for sleep breathing disorders. *In* Principles and Practice of Sleep Medicine, Third Ed., Kryger, M, Roth, T, Dement, W, (Eds.) W. B. Saunders Co., pp 929-939, 2000.

SAMPLE CLAIM FORM

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

AETNA US HEALTHCARE
P.O. BOX 3922

ALLENTOWN, PA 18106-0922

PICA — CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted] THOMAS J

3. PATIENT'S BIRTH DATE MM DD YY: 01 24 1960 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] THOMAS J

5. PATIENT'S ADDRESS (No., Street): [redacted] TRENTON CIRCLE

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): [redacted] TRENTON CIRCLE

CITY: [redacted] STATE: MN

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: [redacted] STATE: MN

ZIP CODE: 55[redacted] TELEPHONE (Include Area Code): (763) 559-[redacted]

ZIP CODE: 55[redacted] TELEPHONE (INCLUDE AREA CODE): (763) 559-[redacted]

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: [redacted]

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY: 01 24 1960 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA US HEALTHCARE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 06/05/2000

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: KEVIN [redacted] M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 780.53
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 05 00	06 05 00	11	1	99002	22ORTHOTIC	1	[redacted]	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 41 1736306 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 12422

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [X] NO

28. TOTAL CHARGE: $ [redacted]

29. AMOUNT PAID: $ 0.00

30. BALANCE DUE: $ [redacted]

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.)
[redacted] D.D.S.
SIGNED 07/17/2000 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
BCBS41444PA PrefOne345501 345502
01019810 00706005 MEDICA43-41011
43-41012 43-41013 43-24146
40-00608 86-00135 86-00133

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SNORING/SLEEP APNEA DENTAL TREATMEN
6600 EXCELSIOR BLVD 952-931-3176
ST. LOUIS PARK, MN 55426
PIN# GRP# 14

790-0129 (12/90) (OCR) 1-Ply

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SAMPLE PRE-TREATMENT DETERMINATION OF BENEFITS LETTER FOR ORAL APPLIANCE THERAPY

Date

Blue Cross Blue Shield of Minnesota
Medical Review Department
PO Box 64265
St. Paul, MN 55164

RE: Robert V. Sleepy
3344 Bedpost Avenue
Somnolia, MN 55444

DOB: 4/14/44
ID #: 444999333
Group #: 4H001-62

To Whom It May Concern:

This letter is to request a pre-treatment determination of benefits for treatment involving oral appliance therapy for management of moderate obstructive sleep apnea condition. Robert V. Sleepy was seen for examination and consultation on September 1, 2000, regarding a complaint of heavy snoring and significant daytime drowsiness. Robert V. Sleepy was referred to this office by Robert Thomas, M.D., for oral appliance therapy to treat the snoring and obstructive sleep apnea condition. Robert V. Sleepy has a diagnosis of moderate obstructive sleep apnea which was confirmed on an overnight sleep study completed at Minnesota Sleep Center on August 15, 2000, in which there was an apnea hypopnea index of 28 events per hour. I have enclosed the sleep study results in addition to our clinic notes for your review.

Nasal CPAP was tried to manage the obstructive sleep apnea, but the CPAP unit was not tolerated. Therefore, it was determined that oral appliance therapy would be indicated to manage this condition.

The oral appliance which will be used is a mandibular repositioning device. This appliance is made of a heat-sensitive acrylic material that will fit over all upper and lower teeth. The appliance is connected by an expansion screw on the right and left buccal segments which allows for adjustment of the mandibular treatment position to optimize the effectiveness of the device and maintain comfort. This treatment is supported by research published by the American Academy of Sleep Medicine in July of 1995 which reported that oral appliances are indicated as a first line treatment for patients with primary snoring and mild obstructive sleep apnea and as a second line treatment after nasal CPAP for patients with moderate to severe obstructive sleep apnea. I would also refer you to an updated article by Dr. Schmidt-Nowara which was published in 1999 and lends further support for use of oral appliances in this situation.

Nasal CPAP was tried without success for the obstructive sleep apnea. Therefore, this patient's situation fits the guidelines supported by the American Academy of Sleep Medicine, and the treatment with oral appliance therapy is medically necessary for management of this condition. The fees for treatment with oral appliance therapy are $_____(CPT #99002-22). Please evaluate and inform us regarding coverage for treatment. If you have any questions regarding this patient's condition, please feel free to contact me. Thank you again for your attention to this matter.

Sincerely,

Robert Q. Dentist, D.D.S.
Enclosures

Sleep Disorders Dental
Treatment Center
12101 East xxxxxxxx
Avenue Suite U
xxxxx CO, 80014
P – xxx-xxx-xxxx
F – xxx-xxx-xxxx

SLEEP DISORDERS SUMMARY REPORT

TO: HUMANA EMPLOYERS HEALTH - Sleep Disorders Reviewing Consultant
Date: 06121100 **Insured:** **Member #** **Group** #
Patient Name: **Date of Birth:** **Plan #**
PCP: MD
Referring Physician: MD

Dr. XXXXX referred Bill xxxx to my office on June 21st,2000 for examination, consultation, and treatment regarding a complaint of obstructive sleep apnea (OSA),heavy snoring, and daytime drowsiness. Based on his examination, history, and the enclosed sleep study, Bill has a diagnosis of central/moderate obstructive sleep apnea, severe hvpopnea, moderate oxygen desaturation, hvpersomnolence, and primary snoring. Epworth sleepiness scale score was 22. Bill's primary areas of blockage seem to be associated with his excessive weight, class ll soft palate, narrow arch width, enlarged pharyngeal folds, enlarged tongue, enlarged uvula, and enlarged lingual tonsils. For his condition, he was first treated with a CPAP devise, which he could not tolerate. This was due to the fact that he could not get a mask to fit properly, suffered strong claustrophobic association, more arousals from the machine and its hoses, along with the fact that he is unconsciously removing the mask at night .Bill's recommended treatment will include placement of an adjustable mandibular repositioning appliance, an aggressive weight loss program, and completion of all necessary dental treatment, to manage the OSA, hvpopnea, and snoring. Based on the results of his examination, the type of appliance used for Bill's recommended treatment will be an adjustable P.M. Positioner. Necessary dental treatment to facilitate placement of his appliance should consist of removal of teeth #'s 1 6 & 32 and restoration of fractured teeth #'s 1 9 & 30 with gold crowns. This appliance causes advancement of the mandible and We base of the tongue, along with an increase in the tone of the tongue and throat muscles. This approach to therapy Or OSA has been proven effective since the late 1980's because of its observed effectiveness in the treatment of OSA and primary snoring. I have enclosed a list of research articles, which pertain to OSA and its treatment using mandibular repositioning appliances. Through clinical experience and research, we have found that the maintenance of the mandible in a forward position will increase the size of the airway and reduce the number of apneas, hypopneas, and snoring to a normal level.

After evaluating Bill I feel that he will greatly benefit from the use of an adjustable mandibular repositioning appliance (CODE 99002-22) fabricated in accordance with the specifications determined by his individual needs. The fee for the appliance is $XXXX and the fee fo the comprehensive history and exam (CODE 99244) performed on November 24, 1999 is $XXXX. The diagnostic code for her Obstructive Sleep Apnea Syndrome is (780.53) and Central Sleep Apnea is (780.51).

If you have any questions regarding Bill's situation, please feel free to call me at (303)696-9364. If you need further information about mandibular repositioning appliance therapy for OSA and snoring, you may contact the Academy of Dental Sleep Medicine (724)935-0836 or me. Please inform us regarding the coverage for the appliance, as Bill would like to gain relief from his disorder as soon as possible. Thank you for your prompt attention to this matter.

Sincerely,

....DDS

Sample Letter to Accompany Claim For Payment of Oral Appliance Therapy

(If no pre-treatment determination of benefits was completed)

Date

John Alden Insurance Company
Route 8883
PO Box 2772
Jacksonville, FL 92731

RE: **Joseph M. Tired**
3388 Anderson Drive
Bensonville, MI 72531

DOB: 5/25/55
Ins. ID#: 44432555
Group #: 5D037-1
Employer: Smith Computers

To Whom It May Concern:

Joseph Tired was seen on September 1, 2000, regarding a complaint of heavy snoring and significant daytime drowsiness. Mr. Tired was referred to this office by Robert Thomas, MD, for treatment of his snoring and symptoms of obstructive sleep apnea. I have enclosed a copy of the letter and office notes from Dr. Thomas prescribing use of an oral appliance to manage his condition. I have also enclosed my office notes from Mr. Tired's initial evaluation. These notes will outline his current symptoms, objective findings, diagnosis, and treatment plan.

Mr. Tired has a diagnosis of moderate obstructive sleep apnea which was confirmed on an overnight sleep study completed at Minnesota Sleep Center on August 15, 2000, in which there was an apnea hypopnea index of 25 events per hour. I have enclosed the sleep study results for your review. Mr. Tired was tried on nasal CPAP but he was unable to tolerate the CPAP unit. Therefore, it was determined that oral appliance therapy would be indicated to manage this condition.

The oral appliance which will be used is a mandibular repositioning device. This appliance is made of heat-sensitive acrylic material that will fit over all upper and lower teeth. The upper and lower portions of the appliance are connected by a mechanism that allows for adjustment of the mandibular treatment position to optimize the effectiveness of the device and maintain his comfort. This treatment is supported by research published by the American Academy of Sleep Medicine in July of 1995, which reported that oral appliances are indicated as a first line treatment for patients with primary snoring and mild obstructive sleep apnea, and as a second line treatment after nasal CPAP for patient's with moderate to severe obstructive sleep apnea. I would also refer you an updated article by Dr. Schmidt-Nowara which was published in 1999 and lends further support for use of oral appliances in this situation. I have enclosed these articles for your review.

Mr. Tired has requested that I submit this letter along with the enclosed claim form to supply adequate information in support of the treatment with the oral appliance therapy that has been completed. This treatment was medically necessary to manage his symptoms of obstructive sleep apnea and was requested by his sleep medicine specialist, Dr. Thomas. If you have any questions regarding Mr. Tired's situation, please feel free to contact me. Thank you for your attention to this matter.

Sincerely,

Joseph Q. Dentist
Enclosures

SAMPLE: DENTIST'S PROGRESS NOTE

PATIENT: **DOB:** **DATE: / /**

Patient is a 46-year-old male who presents with a chief complaint of heavy snoring and significant daytime drowsiness.

PMHx: Patient is currently taking Prilosec for GI reflux and Allegra for nasal and sinus congestion.

History and examination revealed:

A. SLEEP DISORDER

S: Patient reported a history of heavy snoring that affects the sleep of others. He is aware that he snores heavily and he wakes feeling unrefreshed in the morning, therefore he saw his primary physician Dr. ____________ and was referred to Dr.___________ for evaluation of a potential sleep disorder. He had an overnight sleep study completed at _____________ Hospital on October 15th, 2000. The sleep study revealed moderate obstructive sleep apnea with 32 events per hour. He was placed on nasal CPAP which he tried for a 3-week period but the mask and the air pressure were not tolerable for him. Therefore, Dr.____________ talked with him about alternatives to the CPAP and referred him to this office for further evaluation and possible oral appliance therapy.

Patient reported that he awakes feeling unrefreshed in the morning and would nap during the day if given the opportunity. He falls asleep easily while watching TV or reading. He has cognitive impairment at work related to his daytime sleepiness. He has no history of hypnagogic hallucinations or cataplexy. He has a family history of snoring by his father. He reported no significant history of jaw pain, headaches or TMJ symptoms. He has had an increase in weight of about 20# during the past 3 years. He had periodic difficulty with nasal congestion for which he takes Allegra. He sleeps about 7 hours per night, usually on his side. His Epworth sleepiness score at today's visit was 11. Patient is married and has four children ages 19, 17, 15 and 9. He works as a financial analyst at Greenway Financial Corporation.

O: Tongue size: Large.
Soft palate: Moderately long.
Uvula: Long.
Palatopharyngeal area: Moderately crowded.
Maximum mandibular ROM: 50 mm.
RLE equals 13 mm. LLE equals 11 mm. Max prot equals 10 mm.
OJ equals 2 mm. OB equals 5 mm.
Occlusal relationship: L and R Angle Class I.
Mandibular dental midline: 1 mm to R of center.
Occlusal evaluation: Solid contact R and L posterior and anterior teeth.
Wear facets on dentition: Moderate.
Missing teeth: Third molars.
Gingival recession: 2 mm, generalized.
TMJ evaluation: Mild crepitation in R and L TMJs.
No tenderness to palpation in jaw muscles or TMJ capsules.
Neck size: 16 1/2 inches.

A: Moderate obstructive sleep apnea with associated heavy snoring and significant daytime drowsiness.

P:Explained the mechanism of snoring and obstructive apnea and discussed the health risks associated with this condition. Also discussed the treatment options and alternatives to nasal CPAP including oral appliance therapy or palatopharyngeal surgery. We reviewed the limitations, risks, benefits, fees and reasonable expectations of these treatment options. The patient would like to pursue treatment with a mandibular repositioning appliance, therefore, upper and lower impressions were completed and a George gauge bite registration was done.

George gauge at treatment position equals +2 with anterior opening of 3.5 mm.

A pretreatment determination of benefits will be submitted. Patient will return for insertion of mandibular repositioning appliance in 3-4 weeks.

SAMPLE OF PHYSICIAN'S PROGRESS NOTE OR LETTER

MAIN OFFICE (612) 863-
FAX (612) 863-
ST. PAUL (612) 232-
FAX (612) 232-
TOLL FREE (800) 700-

WAYNE L. , M.D.
PAUL R. M.D.
IEVA M. M.D.
RALPH E. , M.D.
WILFRED A. , M.D.
MITCHELL G. M.D.
R. MICHAEL M.D.
THEODORE M. M.D.
THOMAS F. M.D.
KATHY R. , M.D.
PATRICK J. , M.D.

November 25,

Jim , M.D.
Richfield Medical Group
6440 Nicollet Ave
Richfield MN 55423

RE: John

Dear Dr. :

Mr. came back for follow-up. Despite trying at home, he absolutely cannot tolerate the CPAP and has sent it back. Given this, I think he is a good candidate for a dental device and I gave him Jon 's name as a suggested referral. With an RDI of 49, he is a little on the high side but I think that's his best option other than losing weight. He'll also follow-up as needed with you and I told him if he does get the dental device, to let me see how things are going in 3-6 months.

Again, thank you for letting me help in his care.

Sincerely,

Theodore M. , M.D.

TMB:km

cc Jon , DDS

SAMPLE POLYSOMNOGRAM

Nocturnal Polysomnogram Report

Patient Name: [redacted], DENNIS D. Date Fri Jun 02, 2000

Age 41 Sex M Ht. 73" Wt. 225# SS# [redacted]

Sleep Data

Diagnostic		CPAP	
Total Time Monitored	310.0 min.	Total Time Monitored	81.5 min.
Total Sleep Time	240.0 min.	Total Sleep Time	0.0 min.
Sleep Latency	51.5 min.	Sleep Latency	20.0 min.
REM Latency	192.0 min.		
Sleep Efficiency	77.4 %.	Sleep Efficiency after sleep onset	0.0 %
Stage 1	7.1 %	Stage 1	0.0 %
Stage 2	62.5 %	Stage 2	0.0 %
Stage 3/4	16.7 %	Stage 3/4	0.0 %
Stage REM	13.8 %	Stage REM	0.0 %

RESPIRATORY SUMMARY
PreCPAP

Apnea/Hypopnea Index	15.0	Max Duration	18.3 sec.
NARD Index	8.3	Lowest SaO2	94 %

Respiratory Arousal Index: 23.3

* Effective CPAP Pressure Was Not Attained

POSITION SUMMARY
PreCPAP

Total Sleep Time Supine 67.7 % Respiratory Events while supine 98.9%

SNORING SUMMARY

Loud sometimes Crescendo-like snoring noted while supine

I N S T I T U T E
MAIN OFFICE (612)
MAIN FAX (612)
TOLL FREE (800)

THEODORE M. M.D.
WILFRED A. M.D.
KATHY R. M.D.
THOMAS F. M.D.
RALPH E. M.D.
PATRICK J. M.D.

Sleep Institute
Nocturnal Polysomnogram Report

Date: June 2, 2000

Name: Dennis
DOB: 11/17/58

NPSG Study Summary

Nocturnal Polysomnography was performed using the following parameters: EEG, occipital and central; EOG, left and right; EMG, submental and mandibular; Leg movements, left and right; ECG; Oximetry; Airflow, nasal/oral; Thoracic and abdominal respiratory effort. All parameters were digitally recorded and stored. The data was manually scored by our technologists and reviewed by Dr. Kathy Gromer. If necessary, CPAP was initiated and titrated during the night.

Physician's Interpretation

During the diagnostic portion of the sleep study the sleep latency was prolonged at 51.5 min, REM latency was also markedly increased at 192 min, but total sleep time was 240 min. The sleep architecture showed moderate fragmentation due to sleep disordered breathing. Stage III-IV and Stage REM sleep were both reduced. His apnea-hypopnea index was 15 events per hour. He had 8.3 nonapneic respiratory disturbance events per hour. The respiratory arousal index was 22.3 events per hour putting him into the moderately severe range. Maximum duration of an event was 18.3 sec. He did not desaturate below 94%. There was an increase in frequency of sleep disordered breathing when supine. When supine he also had loud, sometimes crescendo-like snoring. The majority of the sleep disordered breathing was obstructive hypopneas with the remainder nonapneic respiratory disturbance events. Periodic limb movements were seen before CPAP at a rate of 11.3 per hour but only .3 per hour were associated with arousal from sleep. His EKG showed occasionally some irregularity to the rhythm. CPAP was initiated but the patient was not able to fall asleep with the mask on and after 81 min of monitoring he took it off and went home. He was advised to follow-up with Dr. .

Impression: Axis A: Obstructive sleep apnea (780.53-0), moderate.

Axis B: Polysomnogram (89.17).

Kathy R. M.D.

KG:km
cc Jonathan , D.D.S.
Jack , M.D.

PATIENT'S LETTER APPEALING DENIAL OF BENEFITS

Date

Blue Cross Blue Shield of xx(State)
PO Box xx xxx
Sleepyville, MN xxxxx

To Whom it May Concern:

My name is Alvin Tired and my member number is xxxxxxxxx-00. I have seen Tom Smith, MD, for a consultation and treatment of my snoring and sleepiness during the day. Dr. Smith sent me for a sleep study that confirmed my ____________ (mild/moderate/severe) sleep apnea condition. I have tried the CPAP machine but I have not been able to tolerate it because of the many side effects.

I am still waking in the morning very tired and have difficulty concentrating and staying alert during the day. Dr. Smith feels that I should find a new avenue of treatment for my problem and he referred me to Dr. Joseph Dentist for treatment with an adjustable jaw repositioning appliance. I have included Dr. Dentist's information along with this letter. I am having difficulty functioning during the day and need treatment for this problem. Please consider this treatment for coverage under my insurance plan as I would like to receive treatment as soon as possible.

Thank you for your prompt attention to this matter.

Sincerely,

Alvin Tired

PRIVATE CONTRACT WITH PATIENT (OPT-OUT OF MEDICARE)

EXECUTION & EFFECTIVE DATE:_________________________________

PARTIES & RECITALS:

A. This is a "private contract" between **{inser tname of dentist or dental practice}** ("Dentist") and **{insert name of patient}** ("Patient") with regard to Patient's agreement to personally pay Dentist for dental services which might otherwise be paid for by the Medicare program.

B. Dentist is not excluded from Medicare under Sections1128,1156,or1892 or any other section of the Social Security Act.

C. Dentist has elected to opt-out of the Medicare program, effective **{insert opt-out date}** and will not be eligible to participate in the program again until **{insert anticipated earliest opt-in}.**

AGREEMENTS:

A. Patient or his or her legal representative accepts full responsibility for payment of the Dentist's charge for all services furnished by the Dentist.

B. Patient or his or her legal representative understands that Medicare limits do not apply to what the Dentist may charge for items or services furnished by the Dentist.

C. Patient or his or her legal representative agrees not to submit a claim to Medicare or to ask Dentist to submit a claim to Medicare.

D. Patient or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by Dentist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

This document is intended as an example of the form of contract you might use if you elect to opt out of the Medicare program. Prior to using this document we advise you to consult with your own legal and financial advisors to:(i)assure that you are aware of the full legal and financial implications of entering into such a contract for both you and your practice group; and (ii) confirm that this contract meets the current requirements of all appropriate law. The Academy is not providing you with legal or financial advice and you should not rely on the Academy to do so.

There are many details pertaining to opting-out that are beyond the scope of these general materials. See, e.g., 42 C.FR. 405.400 et. sqe.

E. Patient or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

F. Patient or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

G. Patient or his or her legal representative warrants and represents that Patient does not currently require emergency care services or urgent care services.

DENTIST

…………………………………………………

PATIENT OR LEGAL REPRESENTATIVE

……………………………………………………

LEGAL PREPRESENTATIVE
RELATIONSHIP TO PATIENT

…………………………………………………….

Notes on Private Contract

Please note the following requirements with regard to the Private Contract:

The contract must be in print, sufficiently large to ensure the beneficiary is able to read the contract.

A copy of the contract (a photocopy is permissible) must be provided to the Patient or to his or her legal representative before items or services are furnished to the Patient under the terms of the contract.

The contract must be retained (original signatures of both patties required) by the Dentist for the duration of the opt-out period.

The contract must be made available to HCFA upon request.

A separate contract must be entered into for each patient for each opt-out period.

OPT-OUT AFFADAVIT

{to be submitted to each Medicare carrier with which you would otherwise file claims}

PROVIDER IDENTIFYING INFORMATION:

Name: **{insert Dentist's full name)** ("Provider")

Address: ____

____

Telephone number: ____________________________________

Provider Numbers: **{insert National provider identifier (NPI)or billing number, if one has been assigned, uniform provider identification number (UPIN) if one has been assigned, or, if neither an NPI nor a UPIN has been assigned, the physician's or practitioner's tax identification number (TIN).}**

PROVIDER HEREBY AGREES THAT:

(A) Except for emergency or urgent care services (as specified in 42 CFR § 405.440), during the opt-out period Provider will provide services to Medicare beneficiaries only through private contracts that meet the criteria of paragraph § 405.415 for services that, but for their provision under a private contract, would have been Medicare-covered services.

(B) The Provider will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the Provider permit any entity acting on his or her behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in § 405.440.

(C) During the opt-out period, the Provider understands that he or she may receive no direct or indirect Medicare payment for services that he or she furnishes to Medicare beneficiaries with whom he or she has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare+Choice plan.

This document is intended as an example of the form of affidavit you might use if you elect to opt-out of the Medicare program. Prior to using this document we advise you to consult with your own legal and financial advisors to:(i)assure that you are aware of the full legal and financial implications of entering into such a contract for both you and your practice group; and (ii) confirm that this document meets the current requirements of all appropriate law. The Academy is not providing you with legal or financial advice and you should not rely on the

Academy to do so. There are many details pertaining to opting-out that are beyond the scope of these general materials. See, e.g., 42 C.F.R. 405.400 et. seq.

(D) During the opt-out period, his or her services are not covered under Medicare and that no Medicare payment may be made to any entity for his or her services, directly or on a capitated basis.

(E) During the opt-out period, Provider agrees to be bound by the terms of both the affidavit and the private contracts that he or she has entered into.

(F) The terms of this affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the Provider during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom he or she has not previously privately contracted) without regard to any payment arrangements the Provider may make.

(G) Any Part B participation agreement that the Provider may have entered into terminates on the effective date of the affidavit.

(H) Understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of § 405.440 apply if the Provider furnishes such services.

PROVIDER

____

Notes on Affadavit

There are specific requirements regarding the time for filing the affidavit. These requirements differ depending on whether or not you are a participating provider. A nonparticipating provider may opt-out at any time by filing the affidavit within 10 days of the execution of the first private contract. A participating provider may opt-out at the beginning of any calendar quarter, provided that the affidavit is filed at least 3 0 days before the beginning of the selected quarter.

Provided that the affidavit is timely filed, the two-year opt-out period commences for nonparticipating providers, on the date of execution of the Private Contract,. The two-year opt-out period for participating providers cannot commence prior to the beginning of the selected calendar quarter. For further details, see 42 C.F.R. 405.410.

Provisions regarding renewal and early termination of opt-outs are set forth at 42 C.F.R. 404.445.

LISTING OF APPLIANCES WITH FDA-510(K) ACCEPTANCE

APPLIANCE	***Accepted for Tx of Snoring***	***Accepted for Tx of OSA***
Snore Guard	x	
Tongue Retaining Device	x	x
Klearway*	x	x
Adjustable PM Positioner*	x	x
Equalizer		x
Nocturnal Airway Patency Appliance (NAPA)	x	x
Sleep & Nocturnal Obstruction Patency Appliance (SNOAR)	x	x
Thornton Anterior Positioner (TAP)*	x	x
Tongue Locking Device	x	
Herbst Appliance*	x	
Adjustable Soft Palate Lifter	x	
Silencer*	x	x
Elastic Mandibular Advance (EMA)*	x	x
Silent Nite*	x	

* Adjustable appliance

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