Dr. Drake reviews the updated practice parameters and explains their impact on your Dental Sleep Practice.

You're back from your first Dental Sleep Medicine course. Now what?! You can do it! Here's advice from Dr. Erin Elliot.

Have to decide between a myriad of devices? Follow these considerations from Dr. Steven Lamberg.

The Whole You Respire Pink EF
Introduced by Dr. Nicole Chenet
MAXIMUM STRENGTH & MINIMAL BULK
WHAT'S BEHIND PILLAR #3?

Years ago, I worked at a large dental lab that made a few hundred oral appliances each month. Time and time again, I found that many dentists were clueless about which devices they should use for their patients. They made decisions based solely on criteria such as price, lab advertisements, or what their golf buddies told them to use without truly understanding or considering the patient’s unique presentation. While the adage that all devices push or pull the mandible forward is true, is it really that simple? Does every device work the same for every patient?

My colleagues at DS3 coined the term “the Four Pillars” to describe the necessary elements of a successful dental sleep medicine practice. These Pillars are Screening, Testing, Treating, and Billing. This month’s issue will focus on the dentist’s primary role in the third Pillar, namely Oral Appliance Therapy (OAT). This is actually the easiest and most intuitive pillar for most dentists to incorporate.

We’re currently in OAT season, the year end rush to maximize insurance benefits. OAT is on your mind. This month’s contributors will provide you with a cornucopia of valuable OAT information from appliance selection criteria and trial appliances to the unveiling of a new device that’s ideal for bruxers and a material that ensures your devices fit properly every time.

The Treatment Pillar is in your wheelhouse. Learn as much as you can here and from other sources. Then, get out there and use this info to help more of your patients. Have a safe and happy holiday season.

We’ll see you in January with our special TMD issue.
At Dental Sleep Solutions, we get a lot of specific device questions. Our DS3 Support Team addresses these questions whether it’s over the phone, through our Help portal, or via the Knowledge Base portal. I talk a lot and I talk fast so when I was challenged to give a fairly in depth overview of my 5 favorite devices, victory was certain..... Or was it? Check out the video to see if I beat the clock while seeing what I have to say about the TAP Elite, EMA, Dorsal, Herbst and Narval.
As dental sleep medicine clinicians we have more than 100 FDA cleared devices to choose from. This can be lead to a great deal of confusion. How do you know which ones to add to your armamentarium?

What should you do for bruxers? What about patients with large tongues? Isn’t each patient’s presentation unique? I’ll focus on a new solution that has worked in my hands and I suggest you check it out in your own practice.

The Whole You Respire Pink Endurance Framework (EF) is a modified Herbst device utilizing an extremely durable alloy material to create one of the strongest yet thinnest products on the market. There is minimal lingual coverage and because of its unique design, there is barely any pressure on the anterior...
A DEVICE WITH MAXIMUM STRENGTH AND MINIMUM BULK APPEALS TO ME AND MY PATIENTS."

"A DEVICE WITH MAXIMUM STRENGTH AND MINIMUM BULK APPEALS TO ME AND MY PATIENTS."

Another key benefit of the Respire Pink EF is its thinness which rivals that of some of the increasingly popular CAD/CAM products. It has significantly less bulk than comparable devices, too. Furthermore, Whole You is able to customize the product so that it fits comfortably even for patients with large mandibular tori. The careful design means it doesn’t rub or touch these areas, a common concern for patients with large tori. It also eliminates concerns for patients with strong gag reflexes, as the appliance doesn’t impinge upon their soft palate area. This increased comfort leads to higher compliance and ultimately, better patient outcomes.

Additionally, the minimal lingual coverage results in maximum tongue space. I have found that due to the increased tongue space, that’s turned their device into particulate due to clenching and grinding, the EF is the solution for them. The device is paradoxical in some ways because it is extremely thin and lightweight but surprisingly durable.

When evaluating which device to use, a device with maximum strength and minimum bulk appeals to me and my patients. The Respire Pink EF device meets those needs with flying colors. Contact me at drndc@verizon.net with any questions about the role the device has played in my practice.

I have observed a less excessive protrusion of the mandible in some cases. This increased tongue space is also ideal for patients presenting with macroglossia or narrow arches.

The device’s telescopic hardware allows lateral and vertical movements, making it ideal for bruxers. If you have a patient
Whole You Sleep Appliance
Respire Pink EF

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1. Increased Tongue Space
2. Reduced Coverage across the Anterior Teeth
3. Suitable for Bruxism

Respire Pink EF Details

- The Chrome framework gives durability and reduced lingual thickness
- Ergonomically designed with telescopic hardware
- 5 mm maximum advancement
- Created for patients with bruxism, as well as for those needing increased tongue space
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- Easily adjustable for jaw position
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And here it is, the end of the year. At GoGo Billing we have always seen a rush of cases come in at the end of the year asking for quick approvals so services can be rendered before January 1st. Have you sent out your letter urging patients to use up their dental benefits? Use them or lose them, right? With most dental insurance plans patients still have a co-pay to contend with and they may be reluctant to spend their holiday money on dental work. They think, “I still have $1000 left of my insurance money, but I will have to spend $1000 or more to use it.” When medical deductibles and out of pocket (OOP) is met, this equates to services covered at 100% or “free” even when seeing an out of network provider. Yes, you read that right!

### WHEN MEDICAL DEDUCTIBLES AND OUT OF POCKET (OOP) IS MET, THIS EQUATES TO SERVICES COVERED AT 100% OR “FREE” EVEN WHEN SEEING AN OUT OF NETWORK PROVIDER.

Without the OOP issue, patients are more likely to move forward with oral appliance therapy (OAT). OAT doesn’t require recovery time or excessive time away from work so most patients can fit an hour or two into their schedules to take advantage of the only time insurance pays at 100%. I suggest you take inventory of all your potential sleep apnea patients seen throughout the year who did not move forward with treatment because of cost. Your billing company or front office team member can call the payer or get online and review their benefits and run an update on their deductible and out of pocket maximums. If you have already had a pre-authorization and network waivers or GAP exceptions completed, remember to check the dates and get an extension prior to treating the patient to cover the procedure date if it has lapsed.

### MEDICARE EXPLICITLY STATES THAT THE BILLED DATE IS THE DELIVERY DATE.

Keep in mind, not all medical plans specify the date of when the E0486 should be billed. With some it’s the impression date and with others, it’s the delivery date. Medicare EXPLICITLY states that the billed date is the delivery date. Be mindful to deliver the appliance before end of year if this is the case. Opening the office for a morning or a full day during your holiday break just to seat appliances will be well worth it.

To put it all into perspective, in dentistry there are yearly maximums to contend with. Once dental plan pays out $1000 or $2000 worth of claims the insurance is “maxed” out and there are no further benefits payable until the benefit or calendar year renews. Most medical plans do not have maximum payouts. It is actually the opposite. This is a wonderful thing for you and your patients!

A common question our benefits and pre-auth department gets asked is in regards to the OOP maximum, also referred to as the out of pocket limit. Is the OOP the same as a deductible? The simple answer is that once a patient has reached the limit set by the plan of maximum OOP costs, services will be paid at 100%. A deductible is an amount of money a patient has to spend before the benefits actually start or any payments are made for treatment other than preventative or routine services. To give every possible scenario or combination available with medical plans would require another full article and frankly, a dull read. When in doubt, call GoGo, the plan, or log in online and find out.

### MOST MEDICAL PLANS DO NOT HAVE MAXIMUM PAYOUTS. IT IS ACTUALLY THE OPPOSITE.

Unsurprisingly, this is also the time of year insurance approvals seem to slow and denials increase, so your persistence is key.

Happy Holidays and a Snore-free New Year!

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MEDICAL BILLING IN THE DENTAL PRACTICE IS AN EVER CHANGING FIELD

which requires thorough understanding of protocols and systems. This can be an extremely rewarding service to offer your patients for sleep apnea, TMD, and many other procedures. Having a plan in place means more revenue for your practice and higher case acceptance.

The course will include one exciting, informative full day lecture with tons of attendee participation including roleplaying and teach-backs. Attendees will also receive a step-by-step claim processing guide, CMS 1500 forms, personalized insurance set-up guide for their office location, Medicare guidelines for treating sleep apnea, and much more. Lunch will be provided.

- Understand medical billing terminology & communicate effectively with the different medical plans
- Know for which services dental offices can bill medical
- Process Pre-authorizations, GAP exceptions, claims, and appeals
- Fill out a medical claim form accurately and completely
- Document and code properly
- Receive a Step by Step Guide to start billing medical insurance in-office on Monday

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CHOOSING THE BEST ORAL APPLIANCE FOR TREATING OBSTRUCTIVE SLEEP APNEA

FOR BOTH YOU AND YOUR PATIENT

What is “the best” for the patient is unquestionably “the best” for the doc. Determining what may be “the best” oral appliance for a particular patient is based on the outcome. If you have found a device that will satisfy compliance and efficacy…and durability, no one would argue with your selection. So let’s take a look at this appliance selection process and help you navigate the myriad of choices we all have.

At this point in the evolution of appliances it is recommended to only use a custom fitted appliance that is adjustable in a minimum of .5mm increments protrusively, and that has been cleared by the FDA specifically for OSA.

Additional qualities that you will need to judge include the following list appearing on the next page.

(not in order of significance)

This is just the beginning of what you should consider when prescribing a particular appliance. Of course the main effect, and side effects, result from mandibular advancement…which all of the appliances achieve in a similar way, and to a similar degree.

A great place to gain experience with appliances is to order demos from your lab and examine them critically. Imagine wearing one of them yourself every night for the rest of your life.

Try some of the common appliances on your patients, or yourself, and see how it goes. Begin trying a: dorsal appliance by Somnodent, Herbst, TAP or a Lamberg SleepWell appliance, ResMed Narval or Panthera D-SAD, EMA, and an Oasys. After making a 100 or so appliances you will begin to appreciate there are many ways to skin the cat. Additionally it must be stated that if a patient has been wearing an appliance successfully in their past, and they need a new one, it makes sense to offer them the same device they had already been happy with.

In the contest between evidenced based science versus opinion, opinion seems to have the leg up on this topic due to the lack of head to head scientific studies. I participated in a blog recently on this very topic. There were over 175 “influencers” who read or contributed to the thread. I don’t believe there was absolute agreement on using a particular appliance for any particular patient, however the group seemed to concur that the many qualities of appliances listed above should be considered and that having familiarity with a few different appliances would be a benefit over just making one appliance. Additionally, it may be necessary to switch appliances sometimes due to breakage, patient comfort, or to satisfy some of the other qualities listed above which may have been missed. My opinion is that the practitioner who does thorough follow-ups and adjustments for patient comfort will ultimately have the highest compliance.

Select a few appliances and perform careful follow-ups to see how comfortable you can make your patients.

Contact Information:
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SteveLambergDDS@gmail.com
Dr. Steve Lamberg has been practicing all phases of dentistry in New York for over 30 years with an emphasis on cosmetic, reconstructive and implant dentistry, and has developed a passion for dental sleep medicine over the last 11 years.

He lectures nationally on topics including occlusion, esthetic dentistry and dental sleep medicine. Most recently, Dr. Lamberg created Lamberg Seminars, offering complete didactic and clinical courses in dental sleep medicine for the entire team.

He is the inventor of the Lamberg SleepWell Appliance “LSW”, which is a patented, FDA cleared intraoral device for the treatment of both snoring and OSA. He contributes articles regularly to Dental Sleep Practice and Dental Economics magazines on topics related to dental sleep medicine.

Dr. Lamberg is a Diplomate of the American Board of Dental Sleep Medicine and is a faculty member for their board examination review course. Additionally he is a Diplomate of the Academy of Clinical Sleep Disorders Disciplines. He lives and practices general dentistry in Northport, New York.

### THE BASIS OF YOUR APPLIANCE DECISION:

1. **Durability (3-5 Years)**
2. **Ease of Use and Cleaning by the Patient (Stains or Retains Odors)**
3. **Cost**
4. **Freedom of Motion Both Laterally and Vertically**
5. **Ability to Control Occlusal Stops (Anterior), Relates to TMJ Health**
6. **Ability to Control Occlusal Stops (Posterior), Relates to TMJ Health**
7. **The Smallest Vertical Possible Interocclusal Space**
8. **The Ability to Limit the Vertical Opening**
9. **If the Appliance is Suitable for Parafuction (Strong Enough or Permissive Enough)**
10. **The Esthetic Nature of the Design**
11. **Where the Advancement Mechanism is (Lateral or Anterior Palate)**
12. **Can the Patients Manage Using the Parts and or Adjustment Tools**
13. **Is the Appliance Medicare Approved (Meets Definition of DME)**
14. **Length of Time It Takes to Receive Appliance Back in Office**
15. **Ability to Be Milled or Printed from Digital Acquisition**
16. **Quality Consistency of Your Laboratory**
17. **Possible Allergies to Materials**
18. **Ease of Modifying Appliance if Dental Work Becomes Necessary**
19. **Ability to Adapt Device to Use Implant Attachments as Necessary**
20. **Effectiveness at Controlling Sleep Metrics**
21. **Issues of Retention Based on Number and Location of Teeth**
22. **Impact the Appliance Will Have on Nasal Breathing**
23. **Comfort for Patients Sleeping on Their Side**
24. **Amount of Tongue Space Consumed by the Adjustment Mechanism**
25. **Does the Appliance Accommodate Lip Seal**
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Wouldn’t it be wonderful to have all of your sleep devices fit the first time, every time? We all know, no matter who is the manufacturer of your oral appliances, not every appliance fits the patient at the first delivery. Many times delivery of a device requires time consuming efforts such as relieving acrylic for path of insertion, adjusting and readjusting wires for retention or worst case scenario returning the device to the lab for a total remake. All this can be frustrating for you, your patients and staff. Finally, you have a solution for the challenge of poor fitting appliances in the Accu-Fit material. This thermally fitted material makes it easy to deliver the oral appliance and adjust to the patient’s dentition. DynaFlex offers the Accu-Fit material in both the Dorsal and Herbst appliances. The body of the appliances are still made of the same dense, durable, lab processed acrylic, while the retention is provided by an inner lining of thermal acrylic. The unique feature of the Accu-Fit material, it allows the appliance to be fitted easily and comfortably each and every time with minimal amount of adjustment and chairtime. Delivery of the DynaFlex Accu-Fit Dorsal or Herbst Appliance . . . the delivery and fit of these appliances is easy and simple. The appliance is returned custom fitted on a set of digitally printed models of your patient’s dentition. The doctor further customizes the appliance by heating the Accu-Fit device in hot water. The water is heated to 150 degrees. The appliances are then placed in the heated water for 5-7 seconds to slightly soften the material prior to fitting them in the patient’s mouth. Once the appliance has been seated for half a minute, the appliance is removed and cooled for final wear. This same procedure is followed for the opposing arch. This simple procedure ensures a perfect fit in a matter of minutes each and every time.

My question to you, why not increase your delivery average? Go to bat with Accu-Fit.

For additional questions contact Gary Quaka at garyq@dynaflex.com.
“Wouldn’t it be wonderful to have all of your sleep devices fit the first time, every time?”

appliance to be fitted easily and comfortably each and every time with minimal amount of adjustment and chair time.

Delivery of the DynaFlex Accu-Fit Dorsal or Herbst Appliance . . . the delivery and fit of these appliances is easy and simple. The appliance is returned custom fitted on a set of digitally printed models of your patient’s dentition. The doctor further customizes the appliance by heating the Accu-Fit device in hot water. The water is heated to 150 degrees. The appliances are then placed in the heated water for 5-7 seconds to slightly soften the material prior to fitting them in the patient’s mouth. Once the appliance has been seated for half a minute, the appliance is removed and cooled for final wear. This same procedure is followed for the opposing arch. This simple procedure ensures a perfect fit in a matter of minutes each and every time.

My question to you, why not increase your delivery average? Go to bat with Accu-Fit.

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Then we treated a couple of the hygienists’ husbands which created a personal story for them. It did a lot to increase their buy-in. Now they look at patients through different lenses. You could say they put down the handpiece and picked up the stethoscope. The office manager began to see that sleep could be very profitable which won her support. I kept this in front of them with regular discussions about sleep during team meetings. We didn’t give up and really created a culture around DSM in our practice.

Brandie: Why do so many dentists have issues successfully implementing dental sleep medicine?

Dr. Elliott: It’s twofold. This isn’t dentistry. We are practicing medicine. We have to collaborate with physicians and deal with medical insurance. A paradigm shift is required. Secondly, the team has to be trained. When the team answers the phone, they have to be able to instill confidence in the patient. That comes from education and experience.

Brandie: How do you create and maintain team engagement?

Dr. Elliott: Don’t we get resistance almost any time we try to introduce anything new? Follow the path of least resistance. Don’t try to make everyone a sleep apnea guru at once. Identify one team member and make them the sleep ambassador. Tell the rest of the team they will be screening and show them how to do it properly. This got us up and running. Eventually, I scheduled a full day in-service and provided a fairly comprehensive overview of DSM. We focused on what OSA is, why it should matter to the team and our patients, dental signs and symptoms, and my favorite devices such as the SomnoDent Herbst Advance. We even tried on CPAP masks.

“Identify one team member and make them the sleep ambassador.”

Then we treated a couple of the hygienists’ husbands which created a personal story for them. It did a lot to increase their buy-in. Now they look at patients through different lenses. You could say they put down the handpiece and picked up the stethoscope. The office manager began to see that sleep could be very profitable which won her support. I kept this in front of them with regular discussions about sleep during team meetings. We didn’t give up and really created a culture around DSM in our practice.

Brandie: Are you going to transition to practicing dental sleep medicine full-time?

Dr. Elliott: This doesn’t have to be full-time job. One device per week can be nice and extremely profitable. It’s a nice add-on to your practice. It’s also added new active patients that need other general dentistry and implants because they didn’t have a dental home. I also get referrals from other DDS that don’t want to treat sleep.

Brandie: What are must haves for a successful dental sleep medicine practice?

Dr. Elliott: In order to successfully bill medical insurance, you have to have a DSM software. At first, we
thought we could just bill fee for service. Following that model, we only did 3 devices. Then we started billing medical and did more devices but we were falling behind, like WAY BEHIND and patients were falling between the cracks. Then we got a DSM software and started using a 3rd party biller. This empowered us to do more, get paid more, and better treat our patients. DS3 has helped tremendously with this. It may seem awkward at first but once you get it, it’s like riding a bike. Also, too many dentists think they’ll just buy a radio spot and the patients will miraculously appear. Dentists are notoriously protective of their time. You have to pound the pavement, meet with physicians, and visit health fairs. We sent intro letters to healthcare providers. Nothing. Dropped off gifts and referral slips. Nothing. Seriously, nothing happened until I got in front of them. We set up lunch and learns. We met with physicians I knew from church, soccer games, and the community as a whole. I spent a day traveling with a local CPAP rep. The face to face piece helps. Now many of those physicians are my patients. It’s different than what we’re accustomed to. However, when you do it right, it’s more rewarding than anything else I’ve ever done in dentistry.

“You have to have an A-Z system in place.”

You have to have an A-Z system in place. When a patient calls or is in your chair you need to know why they’re there, you have to track their progress through DS3, know which device you’re going to use, what to do about side-effects, and how to bill. These are must-haves but you also must have passion and a vision. Your team will support both.
IMMEDIATELY DETERMINE YOUR PATIENTS’ BENEFITS

YOU CAN NOW CHECK YOUR PATIENTS’ BENEFITS BY PERFORMING AN INSTANT ELIGIBILITY CHECK (IEC) THROUGH DS3. JUST FOLLOW THESE SIMPLE STEPS.

FOUR STEPS TO AN INSTANT ELIGIBILITY CHECK:

1. Go to the “Insurance” tab in your patients’ chart and click the “Eligibility Check” button.

2. Type the name of the insurance company into the “Payer ID box.”

3. Scroll down and click submit.

4. A box will appear showing if the patient has active or inactive coverage and their in and out of network benefits including deductibles and co-insurance.

As you’re aware, patients want to know their “estimated” financial responsibility. This feature will enable you to have better informed discussions with your patients at their pre-consult appointments. This will help determine whether or not you want to submit a VOB.

Once you determine if the patient is a candidate for a dental device, your staff can then request a VOB in order for your billers to obtain a pre-authorization. This easy to use feature will save your team time and money.

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Nearly 50% of middle aged adults snore.
20% of adults have sleep apnea.
Less than 10% have been diagnosed.
My partner, Dr. Gy Yatros, used to refer to the 2006 Practice Parameters as “the day the earth shook” in dental sleep medicine. Up until that time, physicians were asking the question: “Should we be prescribing dental devices for our patients?” The first Guidelines, in 2006, said we could use our dental devices as a first line of therapy for patients who were mild to moderate and for severe patients if they refused or could not tolerate PAP therapy. Though it didn’t happen overnight, we have seen more physicians prescribing more dental devices over the last decade. Now comes 2015, the year in which the “Back to the Future” movie took place, and though we’ve progressed in most areas, my take on the Updated Practice Parameters is that we have taken a small step backwards.

The AASM (three sleep MD’s) and the AADSM (two sleep DDS’s) and two staff writers from the AASM made up the task force which looked at about 400 articles published in the last ten years. The task force came up with 11 PICO questions and then looked to the literature for answers. From that, they came out with six new recommendations (two Standards and four Guidelines).

1. Snoring
2. Improve AHI / ODI / AI / Sleep architecture
3. Cardiovascular endpoints
4. QOL improvements
5. Titratable MRDs Vs. Non-Titratable
6. Side Effects
7. F/U SS improve results
8. F/U make a difference
9. Adherence
10. Does one MRD work better than another
11. Predictive Factors
I really encourage you to download the PDF file and take time to read through the entire 55 pages. There is an unbelievable amount of information about the dental devices we use and how our therapy compares to PAP. This info make you a better practitioner and also a much better marketer as you speak with MD’s.

The SIX recommendations:

1. **WE RECOMMEND THAT SLEEP PHYSICIANS PRESCRIBE ORAL APPLIANCES, RATHER THAN NO THERAPY, FOR ADULT PATIENTS WHO REQUEST TREATMENT OF PRIMARY SNORING (WITHOUT OBSTRUCTIVE SLEEP APNEA).** *(STANDARD)*

2. **WHEN ORAL APPLIANCE THERAPY IS PRESCRIBED BY A SLEEP PHYSICIAN FOR AN ADULT PATIENT WITH OBSTRUCTIVE SLEEP APNEA, WE SUGGEST THAT A QUALIFIED DENTIST USE A CUSTOM, TITRATABLE APPLIANCE OVER NON-CUSTOM ORAL DEVICES.** *(GUIDELINE)*

3. **WE RECOMMEND THAT SLEEP PHYSICIANS CONSIDER PRESCRIPTION OF ORAL APPLIANCES, RATHER THAN NO TREATMENT, FOR ADULT PATIENTS WITH OBSTRUCTIVE SLEEP APNEA WHO ARE INTOLERANT OF CPAP THERAPY OR PREFER ALTERNATE THERAPY.** *(STANDARD)*

4. **WE SUGGEST THAT QUALIFIED DENTISTS PROVIDE OVERSIGHT - RATHER THAN NO FOLLOW-UP - OF ORAL APPLIANCE THERAPY IN ADULT PATIENTS WITH OBSTRUCTIVE SLEEP APNEA, TO SURVEY FOR DENTAL-RELATED SIDE EFFECTS OR OCCLUSAL CHANGES AND REDUCE THEIR INCIDENCE.** *(GUIDELINE)*

5. **WE SUGGEST THAT SLEEP PHYSICIANS CONDUCT FOLLOW-UP SLEEP TESTING TO IMPROVE OR CONFIRM TREATMENT EFFICACY, RATHER THAN CONDUCT FOLLOW-UP WITHOUT SLEEP TESTING, FOR PATIENTS FITTED WITH ORAL APPLIANCES.** *(GUIDELINE)*

6. **WE SUGGEST THAT SLEEP PHYSICIANS AND QUALIFIED DENTISTS INSTRUCT ADULT PATIENTS TREATED WITH ORAL APPLIANCES FOR OBSTRUCTIVE SLEEP APNEA TO RETURN FOR PERIODIC OFFICE VISITS - AS OPPOSED TO NO FOLLOW-UP - WITH A QUALIFIED DENTIST AND A SLEEP PHYSICIAN.** *(GUIDELINE)*

Clarifications

“Qualified Dentist” according to the paper:
- Valid State License
- Proof of liability coverage
- Add’l training or experience in DSM

At least one of the following:
- Certification in DSM by non-profit organization (Diplomate ABDSM)
- Dental director of accredited DSM facility by non-profit (AASM/AADSM)
- Minimum 25 Hrs CDE (ADA, AGD) non-profit or dental school in last two years

My recommendations for how YOU can use the new guidelines to your advantage:

- Market to local MD’s that you are indeed a “QUALIFIED Dentist” (If not, GET MORE CE!)
- Reveal your experience (when you get to more than 50 devices)
- Talk to your local MD’s about how you deal with Insurance. Most dentists do NOT understand how important this topic is for a physician who is looking to make a referral.
- Develop strategies for how you will deal with all the snoring patients that the MD’s will start sending to you
- Discuss your protocols for treatment with potential referral sources. Emphasize that you understand the MD makes the diagnosis, the referral, and that you will COMMUNICATE via letters the patient’s treatment progress and then REFER back to MD for F/U titration sleep study.

Again, download the file and READ the paper. It’ll make you a better dental sleep medicine practitioner. In the near future, we will provide a more thorough synopsis of the information in the 2015 Guidelines and I promise to include my usual rhetoric next time!
While oral appliance therapy has its roots in the early 20th century, little notice was taken until tongue retainers and monoblocks created a renewed interest in the 1970’s. But it was the landmark study of Dr. Schmidt-Norwara in 1995 that inspired sleep physicians to take note of the potential significant contribution that oral appliance therapy could make in the world of sleep medicine.

In an attempt to guide treatment triaging, Dr. Schmidt-Norwara proclaimed oral appliances potentially effective in cases of mild to moderate obstructive sleep apnea. This claim was then reiterated in the 2006 Kushida Practice Parameters paper, which guided the AADSM and AASM’s recommended practice policies.

“Oral appliances (OAs) are indicated for use in patients with mild to moderate OSA who prefer them to continuous positive airway pressure (CPAP) therapy, or who do not respond to, are not appropriate candidates for, or who fail treatment attempts with CPAP. Until there is higher quality evidence to suggest efficacy, CPAP is indicated whenever possible for patients with severe OSA before considering OAs…”

AHI continued to be the single most important factor used to attempt to determine the likelihood of success of oral appliance therapy for many years. In retrospect, we now realize with concern that compliance was not even being considered. Neither were other critically important factors, such as our patient’s adaptive capacity which included their genetic resistance to the metabolic stresses of obstructive sleep apnea.

“AHl CONTINUED TO BE THE SINGLE MOST IMPORTANT FACTOR USED TO DETERMINE THE LIKELIHOOD OF SUCCESS OF ORAL APPLIANCE THERAPY FOR MANY YEARS.”

Even back in 1995, Schmidt-Norwara noted that despite the various designs of oral appliances available, a review made it clear that the design didn’t affect the average reduction from an AHI of 49 to 15.

It should be noted that the 2006 Practice Parameters guidelines included patient preference in the considerations of triaging patients, and made it clear that CPAP non-compliance was a clear indication for the use of oral appliance therapy. This conclusion, of course, didn’t prevent those who were evaluating oral appliance success with AHI results in post titration studies from declaring all patients whose AHI was greater than 5 with the oral appliance in place as a treatment failure.

In 2013 Cistulli re-introduced the concept of evaluating an effective AHI. It has been well established that it is common for patients who are considered “compliant” and “successful” with CPAP to use the CPAP 4 hours nightly, therefore sleeping the remaining hours without the internal pharyngeal support. Cistulli, et al demonstrated...
AHI IS NOT THE SOLE CRITICAL DETERMINING FACTOR THAT SHOULD GUIDE TREATMENT DECISION MAKING.

that even patients with severe sleep apnea actually responded equally well to oral appliance therapy, even though their AHI was reduced with less efficacy with oral appliances. They theorized that the reason for this was the result of more hours with pharyngeal support with the oral appliance. Anandam then duplicated this study. The Anandam study demonstrated again equal prevention of fatal events in patients with severe OSA with oral appliance therapy compared to CPAP. This was a well designed study which extended over an 88 month period and included over 200 patients. Anandam makes the point that an AHI can be reduced to 15 and get the reduction in cardiovascular death. He confirmed what Marin 2005, and others found. If you reduce AHI below severe, it is enough to reduce cardiac deaths.

“Most of the studies accepted for inclusion in this guideline did not provide sub-analyses of based on different levels of OSA severity. Therefore, recommendations presented below do not guidance for treating OSA patients with levels of severity.”

In addition, the meta analysis demonstrates that oral appliances are nearly equal to CPAP in reducing hypertension, that oral appliances reduce arousals, and reduce the ODI (oxygen desaturation index) nearly to the levels of CPAP.

It has become increasingly clear that oral appliances have earned a significant place in the world of sleep medicine. Creating a balanced, patient centric program is critical to successful treatment, and we are proud of our model and our attempts to end the competitive nature of sleep apnea therapy.

“IF YOU REDUCE AHI BELOW SEVERE, IT IS ENOUGH TO REDUCE CARDIAC DEATHS.”

The recently published AADSM and AASM guidelines have recognized that AHI is NOT the sole critical determining factor that should guide treatment decision-making:

“ORAL APPLIANCES HAVE EARNED A SIGNIFICANT PLACE IN THE WORLD OF SLEEP MEDICINE.”

ABOUT DR. BARRY GLASSMAN

Dr. Barry Glassman has been treating sleep seriously for the past 15 years. Over that time, he has become a master in the field. Barry is the head of the clinical education program for the Dental Sleep Masters program and maintains a private practice in Allentown, PA, which is limited to chronic pain management, temporomandibular joint dysfunction and dental sleep medicine.

WWW.DENTALSLEEPMASTERS.COM
This January 8th through the 10th in Los Angeles, California, you have the opportunity to join a handful of dedicated, hard-working dentists to "peek behind the curtain" and discover the inner-workings of the dental sleep program that is redefining the way dentists find, treat, and generate revenue from sleep patients.

Dr. Brandon Hedgecock (Dallas, TX) lined up 35 sleep patients to be diagnosed — in a single day.
Dr. Chris Chui (San Francisco, CA) consistently receives between $8,500 and $11,000 for oral appliances.
Dr. Kent Smith (Dallas, TX): Kept close to $160,000 per year in his pocket because he was able to slash his marketing expenses.
Dr. Michael Tong anticipates he will make over to $2,000,000 in 2016 all from treating sleep patients.
Dr. Rebecca Lauck (Dallas, TX) was selected to be part of a group of dentists who will treat NFL players suffering from sleep apnea.

What is the one thing these doctors have in common?

They are all Elite members of the Dental Sleep Masters program.

Dental Sleep Masters is the only dental sleep program that has the depth and breadth of information, training, and support to help members consistently achieve extraordinary results like these.

During the Dental Sleep Masters Reveal you’ll see first-hand how you can turn the old and tired patient referral model on its head and drive a flood of sleep patients to your door. Now you can discover for yourself how the Dental Sleep Masters’ blueprint can radically transform the results you are getting from your sleep practice at the Dental Sleep Masters Reveal this January 8th through the 10th in Los Angeles, California.

The Dental Sleep Masters Reveal is not like any other sleep event you have ever attended. This intensive three-day experience is specifically designed to show you the “insider’s secrets” to developing the clinical and business expertise necessary to have a thriving sleep practice.

During the Dental Sleep Masters Reveal, you will be trained on how to diagnose and treat patients with sleep apnea from Dr. Barry Glassman (Diplomate of the Board of the Academy of Dental Sleep Medicine, and Director of Education and Co-Founder of the Dental Sleep Masters Program) and Dr. Kent Smith (Diplomate of the American Board of Dental Sleep Medicine and Dental Sleep Masters Elite Member). You'll also receive insight and training on the Dental Sleep Masters model from Dr. Avi Weisfogel, the doctor who developed it — along with cutting-edge business practices, innovative patient attraction methods (like working with players from the NFL) and the latest insurance coding best-practices, and a glimpse at the major changes coming in the world of sleep that no one else is talking about (and how you can prepare to thrive in the new environment).

Space is extremely limited, so register now for the Dental Sleep Masters Reveal January 8th-10th, in Los Angeles, California. Got to www.DSMRevealLA.com or call 888.241.1564.

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So, what is TAP Sleep Care? TAP Sleep Care from Airway Management is a comprehensive approach backed by patient-centric science and twenty years of innovation to mitigate sleep-disordered breathing. The results speak for themselves, with more than half a million devices sold and more independent peer reviewed studies than any other oral appliance.

From predictor appliances to custom solutions, the TAP System has a range of advanced devices covering the full spectrum of sleep-disordered breathing.

The newest product in the TAP System is the myTAP. The myTAP is the first of its kind trial and titration device that provides immediate treatment for snoring to obstructive sleep apnea. myTAP’s design is based on the most effective device on the market, the TAP Custom. TAP custom devices continue to be the market leader with over 32 independent peer-reviewed studies and are clinically proven to treat snoring and mild to moderate sleep apnea.

The myTAP can be fit by a clinician or assistant in as little as 15 minutes, allowing you to provide same-day treatment and immediate relief. With a quick and seamless delivery during a routine exam, it integrates into your workflow without the need for a separate fitting appointment.

Defined by accurate molding capabilities, the sleek Precision-Fit trays allow the myTAP to fit effortlessly on the teeth while instantly creating a comfortable, low profile fit. Because they can be reheated and refit, the Precision-Fit trays can be adjusted immediately for maximum comfort.

Once you have determined that your patient is a candidate for oral appliance therapy with the myTAP, the next step in the TAP System is the Custom TAP. The unique design of the TAP empowers patients to fine-tune treatment at home, as well as work with the clinician to achieve the best results. With a single point of central adjustment and ¼ mm advancement capabilities, the TAP prevents uneven bilateral adjustment and allows comfortable titration with the smallest advancement increments on the market. Custom TAPs are available in 3 different hardware options and two available tray liners. These premium lab-made devices are individually fabricated for durable, personalized comfort. With the fixed mechanical hinge and inseparable pivot point, all Custom TAP devices are medicare coded (E0486).

Are you ready to help your patients reap the benefits of improved sleep and overall health?

Contact Airway Management for more information on how to get started.

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YOUR PATIENTS WILL LOOK FORWARD TO SLEEPING WITH US.

START THE CONVERSATION ABOUT TAP SLEEP CARE™

Beyond disruptions in the bedroom, it’s time to recognize that snoring can indicate serious health risks for your patients. TAP Sleep Care from Airway Management allows you to effectively treat the full spectrum of sleep-disordered breathing, starting with myTAP™ on their first visit. So in addition to better sleep, you can also offer a better quality of life.
In recent years, the dental sleep medicine community has seen myriad new appliances enter the market, often claiming to revolutionize how you approach oral appliance therapy (OAT). These claims are almost always unfounded and can lead to uncertainty among clinicians about what’s real and what is mere hype. That’s why I was skeptical about Keller’s newest product, the ClearDream, from the outset. I mean, a dorsal is a dorsal, right? Whether it’s blue or pink or green, who cares. However, with little hype or baseless claims, the ClearDream speaks for itself by taking the familiar, proven concepts and adding several significant improvements. I found there to be three key differentiators when compared with other similar devices.

“THE DEVICE WON’T ABSORB STAIN AND ODOR, NOR WILL THE FINS BREAK...”

Just by looking at the ClearDream, the first difference is immediately apparent. It is made using a clear material, not colored acrylics like all other dorsals. This is important, not for esthetic purposes but because the device is fabricated using Keller’s proprietary clear, clinically unbreakable, non-porous Crystal Clear 450 material. As a result, the device won’t absorb stain and odor, nor will the fins break as can occur with many other appliances. Constant repairs or remakes eat into profits quickly, so durability is paramount. I know this claim about durability is true because it’s the same material they use for NTI Plus splints.

“REPAIRS OR REMAKES EAT INTO PROFITS QUICKLY, SO DURABILITY IS PARAMOUNT.”

Another benefit of the Crystal Clear material is its highly retentive nature, avoiding the need for ball clasps in all but the most extreme situations. This means I don’t incur a bunch of charges for additional ball clasps just to ensure the trays don’t dislodge. At the other end of the spectrum, there is an option for a heat-activated Thermofit liner for patients with deep undercuts or for additional comfort. When I’ve used this option, they drop right in and usually require zero adjustments.
THE THREE KEY DIFFERENTIATORS:

- Clear, unbreakable, non-porous, material
- Less material & increased patient comfort
- The best device at the lowest price point

Chairtime is valuable and with the ClearDream I don’t have to block out extra time because I know I won’t be grinding on acrylic all afternoon. Now, if only my crowns dropped in this easily.

“The three key differentiators:

- Clear, unbreakable, non-porous, material
- Less material & increased patient comfort
- The best device at the lowest price point

The second major difference seems to be a key feature of ClearDream’s design philosophy; less material and increased patient comfort. Utilizing the Crystal Clear material allows for a slimmer, more streamlined, and more comfortable device without compromising durability. There is significantly less acrylic in the anterior than other dorsals with no facial coverage on the maxillary arch and only slight incisal overlap on the mandibular segment which creates an anterior opening. The opening also reduces bulk which increases comfort and may increase comfort and may increase patient compliance. A reduction in overall bulk isn’t limited to the anterior either. The lingual surfaces of the ClearDream are contoured to the teeth; a design feature that maximizes tongue space.

The ClearDream allows for 5.5mm of advancement from the initial position. Like with any dorsal device, it’s imperative you capture an accurate George Guage bite. Along with the bite, I send VPS impressions but Keller can also make them with models or digital scans (something I find useful, since I’m currently digitizing my entire process). Occasionally, I have notches added when I need to use elastics.

The last key differentiator is the price. At only $299 for the hard acrylic version and $319 for the Thermofit-lined ClearDream, you’re getting the best dorsal device on the market for the lowest price point. To paraphrase Gordon Christensen, for a product to be worth using, it has to be better, faster, cheaper, and easier. The ClearDream meets all of these criteria.

To prescribe a ClearDream for your patient, schedule a pickup, or learn more, visit our website or call: (888)919-7577 www.KellerLab.com
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