Dr. Adam Altdorfer, AADSM Qualified Dentist
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Sleep Better APNEA THERAPY
SNORE LESS DREAM MORE FEEL BETTER

American Academy of Dental Sleep Medicine®
Member of the AADSM

Physician's Guide

To Oral Appliance Therapy in Management of Obstructive Sleep Apnea

Your patient has contacted us in regard to fabricating them an oral appliance for OSA.

Our mutual goal is to get them adequate oxygen during sleep, all the time.

The AASM recognizes that oral appliances can be an effective treatment in many mild and moderate OSA patients and an option in severe cases where the patient is CPAP intolerant.

"Back Into CPAP"

Patients who are CPAP intolerant because of high air pressures often benefit from hybrid therapy - where the oral appliance allows them to get back into their CPAP by opening their airway and allowing CPAP use at a lower, more comfortable pressure. Our intention is to get patients back into their CPAP if this is what they need for full treatment.

After their custom oral appliance is fabricated and adjusted symptomatically and confirmed through pulse oximetry, you will be asked to order a titration sleep study to confirm efficacy. The sleep technician will titrate the appliance to full treatment or add a small amount of CPAP if indicated or tolerated.

There are only 2 things you need to send us:

1. **Letter of Medical Necessity (included in this packet), and**
2. **Copy of Diagnostic Sleep Test <3 years old.**

If your patient has not been diagnosed with OSA, or if they have not had a sleep test in the previous 3 years, please contact them for evaluation or to update their records.

After we receive the 2 documents from you, we will contact your patient and proceed with oral appliance therapy. You will receive updates on your patient's progress.

Thank you for being involved in your patient's desire to have full treatment for their OSA. Feel free to contact us if you have any questions about their care.

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Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea And Letter of Medical Necessity Form

In order to facilitate prompt insurance reimbursement for our mutual patient, please sign and fax or email this form with a copy of the **most recent diagnostic sleep test results** (if available) to the office address listed at the top of this document. Once the sleep apnea appliance is in place, a follow-up study will be required to validate the efficacy of treatment. We will contact your office to have you arrange this for the patient.

PRESCRIBING PHYSICIAN INFORMATION			
Name:	NPI:	License#:	
Phone:	Address:	City:	Zip:
PATIENT INFORMATION			
Name:	DOB:	Gender (assigned at birth):	
Insurance Company:	Group No:	Account/ID No:	
Phone:	Address:	City:	Zip:

PRESCRIPTION INFORMATION

CODE - E0486 (Quantity: 1) Prescription to be filled by: Adam Altdorfer, DDS - Sleep Better Apnea Therapy
The patient referred with this form has been evaluated by the above physician and has been diagnosed, using acceptable medical criteria, to have:
(CHECK ALL THAT APPLY)
Primary Diagnosis:

- ☐ ICD 10 G47.33-Obstructive Sleep Apnea
- ☐ ICD 10 G47.30-Upper Airway Resistance Syndrome
- ☐ ICD 10 G47.30-Hypersomnolence w/Sleep Apnea (Excessive Daytime Sleepiness)
- ☐ ICD 10 G47.30-Insomnia w/ Sleep Apnea
- ☐ ICD 10 G47.61-Sleep-Related Limb Movement
- ☐ ICD 10 R06.83-Snoring

Secondary Diagnosis (Comorbidities): _____
Apnea Hypopnea Index (AHI):_____
Minimum Oxygen Saturation (SpO2 Nadir):_____ Respiratory Disturbance Index (RDI):_____
Date of Last Diagnostic Sleep Test:_____ Date of Titration Sleep Test:_____
***REQUIRED- CHECK ONE BELOW FOR INSURANCE COVERAGE:**

- ☐ *The patient **prefers OAT** over CPAP or surgical alternatives for Mild or Moderate OSA.
- ☐ *The patient is **CPAP intolerant or non-compliant.**
- ☐ *The patient requires **combination therapy** of OAT in conjunction with CPAP.
- ☐ *The patient is not a candidate for CPAP Therapy.

Explanation (if necessary): _____
Duration of PAP Treatment:
Start Date _____ End Date _____ Still Currently Using _____ Yes _____ No

MEDICAL NECESSITY VERIFICATION AND PRESCRIPTION AUTHORIZATION

As the patient's treating physician, I deem this therapy to be MEDICALLY NECESSARY.
PHYSICIAN'S SIGNATURE:_____ DATE:_____

Statement of medical necessity: The above patient had a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary. Currently, Medicare has a code (E0486) with the following descriptor, "ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS" Treatment duration will be at least one year and could be required for the remainder of the patient's life. If you should have any questions, please contact the prescribing physician.