SPECIAL ARTICLES

http://dx.doi.org/10.15331/jdsm.4440

The Dentist-Physician Partnership

Kelly A. Carden, MD, MBA

St. Thomas Sleep Specialists, Nashville, TN

Collaboration among dentists and dental specialists is not new. Collaboration among physicians and physician specialists is not new. What is novel is the need for a different kind of partnership—that of the dentist and the physician—for the sake of patients suffering from obstructive sleep apnea (OSA). Some have entered into this novel partnership with ease and grace; for others it has been more of a struggle. The two fields have a host of differences: education and training, terminology, practice regulations, types of insurance and billing, as well as documentation styles. Dental sleep medicine requires the dentist to leave part of the dental world behind and embrace the medical world with regard to communication, documentation, and insurance/billing. This can be a challenge, but the satisfaction of contributing to the health and happiness of sleep apnea patients is well worth the effort.

Exposed to dental sleep medicine since the time of my fellowship training, I have long advocated for the use of oral appliance therapy (OAT) in appropriately selected patients. We know that the medical and surgical treatment options for OSA are not embraced or suitable for all patients. It has been a huge benefit to my patients for me to be able to offer OAT. At the time of this publication, there are only 197 board certified dental sleep medicine practitioners in the entire United States (and 17 in Canada). This number is simply insufficient to manage the expansive need. I would strongly encourage interested dentists to study sleep medicine and embrace board certification.

So…maybe you are new to the idea of practicing dental sleep medicine or maybe you have taken a course or even made an appliance for yourself as a trial. What is next? Although you did not have any business courses in dental school, it might be time to develop a business plan to see if including dental sleep medicine within your practice is a viable option. In addition to a budget, this would likely include some sort of "SWOT" analysis of your strengths (S), weaknesses (W), opportunities (O), and threats (T) with regard to the new endeavor. Only you will know the SWOT components as they relate to your particular practice. One important factor is whether your office is prepared to manage medical insurance in this ever-changing landscape that is health care. As for the external environment, in addition to evaluating population statistics in your geographic area and other site-specific information, you will want to size up the competition. Who are the interested dentists in your area? Have you checked the American Academy of Dental Sleep Medicine (AADSM) website (www.aadsm.org/findadentist.aspx)? Are your competitors board certified in dental sleep medicine? What kind of training have they had? How long have they been practicing dental sleep medicine? How many different appliances do they use? Do they have relationships with physicians/centers/laboratories? Read the websites of your potential competitors to get an idea.

In addition, you will want to know who your physician colleagues might be. The Internet is your friend here again. Do your homework. Find out how many board certified sleep medicine physicians there are in your area. The website sleepeducation.com is a good starting place. You can search for American Academy of Sleep Medicine (AASM) accredited sleep centers in your area by full address, zip code, or city/state. Most of the listings include the website of each individual sleep center. The websites can help with basic information about the sleep centers and the doctors who are affiliated with them. You will want to know how many sleep centers/laboratories are in your area. How many beds does each center have? Can you get a sense of the volume of home sleep apnea testing (HSAT) they perform? How many and who are the doctors who work with them? Are there dentists on the team already? Although it would make life in reconnaissance easier, you may not be able to discern whether or not the physician has an association with a dental sleep medicine practitioner. Note that if the physician is affiliated with a large hospital network or university, there may be a dentist working within that network (or even in the sleep medicine clinic) already.

It is also important to remember one thing when researching the physicians: sleep medicine is an amalgamated field of medicine (do I get dental points for that one?). There are pulmonologists, neurologists, internists, psychiatrists, otolaryngologists, anesthesiologists, pediatricians, and others who work in the field of sleep medicine. Some have elected to practice sleep medicine full time. Others may continue to practice in their primary field as well. Additional Internet research may be required at this point. Be aware that many of the transparency websites out there pull data from various sources that may or may not be correct or up to date. Reading patient reviews can be helpful as well. Unfortunately, there is not a "master list" of all board certified sleep medicine physicians available on the World Wide Web. Prior to 2007, the American Board of Sleep Medicine (ABSM) was responsible for administering the Sleep Medicine Specialty Examination. The list of physicians who achieved board certification through the ABSM is available at the time of this printing at www.absm.org/sleepmedicinespecialty.aspx. In 2007, several member boards of the American Board of Medical Specialties began administering subspecialty certification examinations in sleep medicine. The ABSM web address above also has a listing of these member boards (and their websites) which includes the following: American Board of Anesthesiology, American Board of Family Medicine, American Board of Internal Medicine, American Board of Pediatrics, American Board of Psychiatry and Neurology, and the American Board of Otolaryngology. If a physician has achieved board certification through one of the above boards, that information may be available on that particular board's website. For example, the American Board of Anesthesiology has a "Verify a Physician's Certification" on the home page for the organization.

What if you have now decided to take the plunge? You have enough information to put more than a toe in the proverbial

water. How in the world are you going to establish contact with your would-be partners—the physicians? Reaching out may feel foreign and very uncomfortable. You could approach it one of several ways. The options include writing a letter of interest, knowing that you run the risk that it might never see the eyes of the physician in the modern medical office setting, instead ending up in the file that is circular. You could call to speak with the physician or set up a meeting to do so. Either way, once you get your foot in the door, it is time to express your interest to be involved in the care of the OSA patient. Let the physician know where you are in the process. Are you board certified in dental sleep medicine? As you know, we can look it up. Are you involved with the AADSM? Is your office accredited by the AADSM? How many appliances have you fabricated? How many different appliances do you use? What have you done in the name of education? Have you tracked your patients? How do you maintain records? Do you send the patients back to the physician for repeat study to determine efficacy and to potentially calibrate the positioning? What is your success rate and how do you define success?

If you have gotten this far, then try to get an understanding of the physician's familiarity and current utilization of OAT. Make sure you are well aware of the current practice parameters and standards of practice regarding OAT. A literature search and review would be optimal. Know your stuff and bring everything that you might need (but you may or may not use in the discussion with the physician). Firstly, you may want to discuss the efficacy data of OAT from the literature. Be mindful however that in determining the effectiveness of positive airway pressure therapy (PAP), the efficacy is measured in the device's ability to suppress the apnea-hypopnea index (AHI) below 5 events per hour of sleep. Until recently, many efficacy studies in dental sleep medicine used alternative markers of success such as improvement in patient symptoms, reduction in AHI by a certain percentage, suppression of the AHI below 10 events per hour, or the like. Be sure to compare apples to apples in this scenario. Secondly, once you have discussed the efficacy of OAT in mild, moderate, and severe OSA, you will want to discuss that last group in more detail. There is little room for debate that positive airway pressure is the first line treatment for the more severe cases of OSA. However, if a patient is intolerant to positive airway pressure, other options must be explored. Options include weight loss, surgery, oral pressure therapy, expiratory positive airway pressure (EPAP) via nasal valve, and hypoglossal nerve stimulation. Although the goal is full control of the OSA, some patients may be referred to you for "salvage therapy." This means that the expectation may not be full control of the OSA, but instead as much control as possible in an effort to reduce the negative impact of the OSA on the health and quality of life. You will also want to have some familiarity regarding the use of combination therapy (OAT and PAP at the same time). In addition to the above, be prepared to talk about the ideal patient characteristics for OAT, the contraindications (absolute and relative ones) to OAT, the side effects and how they are managed, medical billing and the concept of bundled services, protocols for follow-up, medical insurance coverage, and the general cost.

If the conversation is turning into a partnership, there are other components to address. How will this all work? You will want to know how to refer a patient for evaluation (generally to rule out OSA) to the physician. What paperwork is needed for the referral? What insurance plans are accepted? Are both in-laboratory polysomnography and HSAT offered? In some cases, you will not be referring to an individual physician but instead to a sleep center which then assigns the referral to one of their physicians by center protocol. You will want to understand the proper channels going forward. Also, you must be mindful of the regulatory aspects of the Health Insurance Portability and Accountability Act (HIPAA), including for example that referrals emailed on the World Wide Web are not considered "protected" information.

On the flipside, you may want to discuss how the physician is going to make a referral to you for a patient with known OSA. In addition to a referral, the physician will send you a prescription for the OAT, the medical indication, and medical necessity for the device. This may be in the form of preprinted prescription pads, a web-based document, a simple Word document or form, or may be encompassed in the electronic health record. There are certain elements that the prescription must contain and one should be aware of federal and state laws with regards to such. Similar to a prescription for PAP durable medical equipment (DME) to a DME company, additional information such as the pertinent sleep study report, clinic notes, insurance information, and full demographics is required.

After a referral is made in either direction, it is important to know what is to happen next. If you refer a patient to a physician for an evaluation, it is standard practice that the physician send a consult note back to you. This note generally consists of a chief complaint/reason for visit, a history of present illness and sleep history, past medical and surgical history, current medications, allergies, social history, family history, and a physical examination including vital signs. Lastly, there is a section of the documentation called "Assessment and Plan." In this section, the physician provides a brief summary and assessment of the case as well as the plan for work-up and/or treatment. It will be important for you to familiarize yourself with the typical medical documentation. Your partners in medicine will likely have the expectation that you document in the medical format (you are treating a medical disorder after all). Not only will this be important for your initial visit with a patient, but on follow-up patient visits as well. One common approach to the documentation of a follow-up patient visit is that of a "SOAP" note. The acronym stands for the four basic elements of the note itself: subjective, objective, assessment, and plan. The subjective component is the patient report with regards to the problem at hand. This might include details such as how they are tolerating treatment, current sleep quality, daytime symptoms, side effects of treatment, and the like. The objective component is the clinician's observations such as the patient's vital signs, physical examination findings, and other objective information (adherence to therapy data, recent laboratory tests, x-ray results, etc). The assessment is just that—the clinician's assessment of the current situation. The plan is the discussion or outline of the next steps in the treatment of the patient. Whether it is an initial evaluation or follow-up evaluation, it is general practice that the clinician send a copy of that documentation to other team members involved in the care of the patient. This documentation is your lifeline of communication.

Now that we have the documentation out of the way, I am going to talk about the elephant in the room—sleep testing—and more specifically HSAT. HSAT, in my humble opinion, is the greatest threat to the physician-dentist relationship. Confusion about the "who" is what leads to the discontent (who orders, who provides, who interprets, who bills, who explains, etc). As a point of education, according to the Current Procedural Terminology (CPT) Codebook, a sleep test is defined as "the continuous simultaneous monitoring of physiological parameters during sleep." This includes the most simple home pulse oximetry study that determines oxygen levels during sleep to the most complicated in-laboratory polysomnography study with full EEG. With regards to sleep testing, including that done in the home, the position both of the AASM and the AADSM is that OSA is a medical disease that must be diagnosed by a physician. Furthermore, because snoring is a common symptom of OSA, a diagnosis of primary snoring can be made only by a physician who has ruled out OSA. The best treatment outcomes will result from a like-minded partnership where the physician diagnoses OSA, and in the appropriately chosen patient, requests that a qualified dentist provide an oral appliance if it is suitable from a dental point of view. Two clinicians coming to the same mutual decision on behalf of the OSA patient represents the true collaborative spirit. Subsequently, the dental follow-up should be by the dentist, and the sleep apnea and sleep medicine follow-up should be by the physician. The latter is paramount when considering that it is not uncommon for OSA patients to have ongoing sleep disordered breathing despite symptom improvement with OAT. In this case, follow-up testing may indicate that further advancement of the mandible is necessary for full control of the OSA. When advancement is not possible or not tolerated, inadequate control of sleep apnea may indicate that other treatment options should be explored and potentially prescribed. Lastly, even with adequate control of OSA, the sleep apnea patient may also require ongoing sleep medicine follow-up for residual hypersomnia and/or comorbid sleep disorders such as insomnia, restless legs syndrome, and the like.

It is not just the national organizations that have drawn the line in the sand. Although the debate rages on in some states, in others, state dental boards have weighed in regarding the use of sleep tests by dentists. For example, the New Jersey State Board of Dentistry responded to inquiries posed by the New Jersey Dental Association as to whether it is within the scope of practice of a New Jersey licensed dentist to perform a sleep study, interpret a sleep study, and/or dispense the machinery to perform a sleep study. The Board ruled "no" to all three, but did note that the dentist is permitted to work with other medical professionals to treat sleep apnea and be within their scope of practice (New Jersey State Board of Dentistry, Public Session Minutes 4/1/2009). With this and other rulings in mind, you are advised to contact the dental licensing board in your state to verify the approved scope of practice. For each of your patients, you are also encouraged to review the specific insurance policy requirements related to who may order, perform, and read sleep tests.

We each have an incredibly valuable role to play in the treatment of the OSA patient. The sleep medicine physician should perform a complete sleep medicine evaluation and, if medically indicated, perform the appropriate diagnostic testing for OSA. In turn, it is the dentist who is trained in dental sleep medicine, who should provide safe, effective, and well-tolerated oral appliance treatment. Dual ownership is the avenue to success. Coordination, communication, and collaboration between dental sleep medicine practitioners and sleep medicine physicians ensures that we achieve the ultimate goal—the highest quality of care for patients with OSA.

CITATION

Carden KA. The dentist-physician partnership. *Journal of Dental Sleep Medicine* 2015;2(1):23–25.

SUBMISSION & CORRESPONDENCE INFORMATION

Submitted for publication December, 2014
Accepted for publication January, 2015

Address correspondence to: Kelly A. Carden, MD, MBA, 300 20th Avenue North, Suite G-8, Nashville, TN 37205; Tel: (615) 284-7533; Fax: (615) 284-7575; Email: kcardenmd@gmail.com

DISCLOSURE STATEMENT

The author has indicated no financial conflicts of interest.