SPECIAL ARTICLES

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Commentary: The Economic Climate Affecting the Future of Dental Sleep Medicine

Jerome A. Barrett

Many general dentists are drawn to the practice of dental sleep medicine (DSM) because treating patients with sleep apnea is a rewarding and unique type of medical service. Unfortunately, due to the difficulty of navigating the medical insurance industry, the downward trend of reimbursement rates for oral appliance therapy (OAT), and the high cost of appliances, many dentists are hesitant to start practicing DSM and those who do often worry about the viability of their DSM practices. In many cases the dentist's ability to continue to treat and care for DSM patients is only feasible because the revenue loss associated with practicing DSM is offset with general dentistry services. If dentists want to ensure the future viability of DSM and the quality of patient care, they must consider better management of costs and active pursuit of the best and/or most cost-effective treatment options for their patients. Doing so will improve the financial state of the dentist's practice while maintaining quality of care.

The economic climate faced by dentists treating OSA and snoring is most influenced by (1) medical insurance company polices for providers and policy holders; (2) access to care by patients; and (3) the cost of the oral appliance. Accepting these three influences is a necessary first step, followed by an understanding that influencing significant change with any of them is nearly impossible. What is possible is to develop a practice model that acknowledges the effect of these influences and allows dentists to continue to treat patients with a diagnosis of OSA and grow their DSM practice. This commentary will focus on four recommendations for consideration:

1. Consider a fee-for-service billing model. Each practice must do an in-depth analysis of their practice costs and the effect of being in-network on referrals, but dentists should not be under the impression that they must be in-network providers to operate a successful DSM practice.

2. Consider adopting an unbundled billing model when using a fee-for-service model. Each service (i.e., screening, testing, fabrication, cost of the appliance, delivery, calibration, follow-up care, etc.) should be charged individually, allowing the patient to better understand the services they receive and the cost for each.

3. Consider ensuring that patients have access to OAT by:
    a. Ordering or distributing home sleep apnea tests (HSATs) to patients suspected of having OSA or snoring, when not prohibited by the state dental board.
    b. Prescribing OAT for patients who have documentation of a physician diagnosis, when not prohibited by the state dental board. Following treatment, results of therapy should be communicated to the patient's medical provider.
    c. Developing referral relationships with multiple primary care and specialty physicians.

4. Consider taking steps to control the cost of the appliances selected for patients.

DISCUSSION

Recommendation 1:

Fee-for-Service Billing Model - Consider a fee-for-service billing model. Each practice must do an in-depth analysis of their practice costs and the effect of being in-network on referrals, but dentists should not be under the impression that they must be in-network providers to operate a successful DSM practice.

Some dentists want to and can achieve a viable practice model as Medicare providers or in-network providers if they are willing to invest the time and money in securing the contracts. However, many dentists hesitate to even get involved with DSM because they are intimidated by medical insurance, which is a valid concern. Medical insurance companies are particularly difficult to work with and virtually impossible to change. In brief: (1) Dentists are not likely to be successful in getting medical insurance policies to change, whether for coverage or contracting. (2) Dentists are not likely to successfully

influence reimbursement rates or coverage rules. (3) With high deductibles, coinsurance, and out-of-pocket maximum copayments patients are often paying a fee that is equivalent to out-of-pocket charges for their health care regardless of their health insurance "benefits." Given these barriers, fee-for-service is something to strongly consider.

Becoming an in-network provider and navigating the policy requirements, low reimbursement rates, and high premiums, deductibles and copayments for patients are all barriers many dentists are facing. The following is a simplistic overview of how the medical insurance companies function to explain why these barriers exist.

Medical insurance companies' systems are designed around medical doctors diagnosing a disease and providing treatment in large groups such as health systems, hospitals, and multi-office practices. Having this simple framework in place offers insurance companies convenience and efficiency. Dentists do not figure into these systems. OAT is one of very few dental services that some medical insurance covers. There is no benefit to insurers to adjust their systems to easily credential dentists who provide one medical service.

Additionally, OAT is classified as durable medical equipment (DME), not as a medical service or treatment provided by a medical doctor. Oral appliances are grouped into the same medical category as crutches, wheelchairs, and the like. Most DME is distributed by large companies that specialize in the DME industry. Insurance companies' systems are set up to accept physician orders for DME, such as a continuous positive airway pressure unit, which are then fulfilled by a DME company. But, oral appliances are not distributed by DME companies and are not manufactured in bulk, but rather they are fabricated individually for a specific patient. To further complicate the matter, there are more than 100 FDA-cleared oral appliances, making it difficult for the insurance company to assess which appliances should be covered. In the eyes of the insurance company, all appliances do the same thing - open the airway. Oral appliances as a custom-fabricated therapy provided by individual dentists fall outside of the insurance companies' usual systems and present added administrative headaches.

Access to insurance plan participation is difficult at best. It should be understood that medical insurance companies are in the business of NOT paying insurance claims for their policy holders. Reducing the amount paid for medical services increases the likelihood of delivering higher returns to their shareholders. One way this is achieved is that insurers set arbitrary rules that limit the number of in-network providers all in the name of "quality of care". Complicating the issue for DSM, dentists who are accepted as in-network providers on the medical plan often must also become in-network providers for the dental plan. The reduced rates offered for general dentistry services are often a dealbreaker for the dentist.

For those who are successful becoming an in-network provider, the policies are ever-changing, the types of oral appliances covered are often limited, and the requirements for coverage often require a tremendous amount of administrative work by the dental practice. Being an in-network provider can also lengthen the time to treatment as the dentist navigates the policy requirements, and the patient may not understand what is covered and is not covered by their insurance.

Dentists often view becoming an in-network provider as the magic solution to increasing referrals and patient acceptance because the cost of OAT will be covered by insurance; however, it is important to understand that having insurance does not mean that the full cost of OAT will be covered by insurance.

In 2021, the annual health insurance premium increased by 4%, topping $22,000 for a family of four. The only way to avoid premium increases is to accept higher deductibles, coinsurance, and out-of-pocket maximums or to limit the network of providers.[1]

The American Academy of Dental Sleep Medicine (AADSM), as an employer, recently faced this very issue when renewing its health insurance in 2022. Premiums for the current insurance plans increased 13% between 2021 and 2022. However, to shift to a new plan while keeping the same network of providers required a 300% increase in the deductible, a 10% increase in the coinsurance, a 100% increase in the office visit co-payment, a 367% increase in out-of-pocket maximum, and a significant increase in the cost of prescriptions. The health insurance offered by the AADSM tracks with the average healthcare offered by employers, so it is likely that employers throughout the country will be facing similar decisions, requiring employees to either pay more for their premiums or more for services.

In 2021, the average deductible, the amount paid by the insured, for an individual was approximately $1,700, the coinsurance was 20%, and the out-of-pocket maximum significantly varied, with more than 27% of individuals having an out-of-pocket maximum of $6,000 or more.[1]

How do all of these numbers affect the cost of OAT to a patient? For example, assume that an insured patient has a $1,700 deductible, 20% coinsurance, and a $6,000 out-of-pocket maximum and is requesting an oral appliance that costs $2,000. Unless that person has had healthcare costs exceeding $6,000, that individual will be paying somewhere between $400 and $1,940 for their appliance.

What all of this comes down to is that dentists need to do a cost-benefit analysis to determine whether the cost of getting in network, the administrative burden of the claims process, and adjusting models of care to align with insurance policies is worth the effort when in reality patients may be paying out-of-pocket for a significant portion of their OAT treatment, regardless of their insurance coverage.

Recommendation 2:

Unbundled Billing - Consider adopting an unbundled billing model when using a fee-for-service model. Each service (i.e., screening, testing, fabrication, cost of the appliance, delivery, calibration, follow-up care, etc.) should be charged individually, allowing the patient to better understand the services they receive and the cost for each.

Oral appliances are considered DME and are often reimbursed as a global fee. For Medicare, all services provided from the initial evaluation to the 90-day follow-up examination, as well as the cost of the appliance and related laboratory services (impressions, digital scans, bite construction, etc.) are combined into a single fee.

By unbundling the dentist's services in a fee-for-service model, patients can see exactly what they are getting with the services provided. It also recognizes that each patient is different and may require different services throughout treatment. From the patient's perspective, it can alleviate uncertainty about what the final cost will be, instead offering them a clear path on what they can expect to pay and when. Patients will not have to wait for lengthy predetermination submissions or receive surprise bills after a denial of coverage by the medical insurance provider. Administrative time can be reduced by cutting out the insurance and can strengthen a member's ability to estimate financial returns on providing OAT.

Dentists are encouraged to always present a transparent treatment plan and show the gross costs with any appropriate discounts/payment plan options. This demonstrates to the patient that everything possible has been done to make the treatment affordable.

Recommendation 3:

Increase Patient Access to OAT - Consider ensuring that patients have access to OAT by:

a. **Ordering or distributing home sleep apnea tests (HSATs) to patients suspected of having OSA or snoring, when not prohibited by the state dental board.**
b. **Prescribing OAT for patients who have documentation of a physician diagnosis, when not prohibited by the state dental board. Following treatment, results of therapy should be communicated to the patient's medical provider.**
c. **Developing referral relationships with multiple primary care and specialty physicians.**

In Emerging Models: 30 Years of Breaking through Dental Sleep Medicine Barriers to Help Patients, Schwartz et al outlined a model for care in which dentists expand their services to help address access to care issues by ordering or distributing HSATs for patients suspected of having OSA and providing OAT for patients who may have abandoned CPAP or simply prefer an oral appliance.[2] Both of these services require a licensed physician to diagnose OSA, but they reduce expense and layers for patients and allow streamlined workflow processes, while removing some burden off the shoulders of physicians.

During its 2017 strategic planning retreat, the AADSM board of directors was decisive in its goal to increase the number of trained dentists to help meet public burden of OSA. This caused a drastic redirection for DSM. The board approved a plan to standardize the practice of dental sleep medicine as well as the education requirements for the AADSM Qualified Dentist and American Board of Dental Sleep Medicine (ABDSM) diplomate designations. This plan evolved into the *Dental Sleep Medicine Standards for Screening, Treating and Managing Adults with Sleep-Related Breathing Disorders*[2] and the AADSM Mastery Program. During this same time frame, the American Dental Association also published its policy on the role of dentists in managing sleep-related breathing disorders,[3] bolstering the role of dentists in treating OSA and snoring. Currently, more than 1,500 dentists have attended all or part of the AADSM Mastery Program, and there are more than 1,800 dentists who have earned the AADSM Qualified Dentist or ABDSM Diplomate designations. To put these numbers in perspective, it took the AADSM and ABDSM 27 years to get 600 AADSM Qualified Dentists and ABDSM Diplomates on board, and only 4 years to more than triple that number. The growth of the profession accelerated to previously unthought of levels.

Unfortunately, throughout this same time period, the number of undiagnosed and untreated patients with OSA has continued to increase. In 2015, the American Academy of Sleep Medicine (AASM) commissioned a study performed by Frost & Sullivan.[4] They found that approximately 23.5 million adults in the US had undiagnosed and untreated OSA. More recent studies have that number increasing by nearly 50%.[5] From an economic perspective, most dentists providing DSM services could stop and continue to thrive with successful general practices, but the truth of the matter is that dentists are necessary to help reduce the public burden of OSA.

Offering these additional services provides a convenience to patients and referring physicians, potentially setting a dental practice apart from others. There are a handful of states that prohibit dentists from providing home sleep apnea testing or prescribing OAT for a patient diagnosed with OSA by a medical provider. Some insurance companies and Medicare also have policies preventing dentists from offering these services. The insurance companies and Medicare are within their rights to do this. However, it is important to remember that they merely set policy for the lives they cover. Under the fee-for-service model outlined earlier, in the states that do not prohibit dentists from providing these services, dentists could be of great benefit by screening patients, providing

HSATs to those suspected of OSA, having a physician diagnose OSA, delivering an OAT, and communicating care to the patients' physicians.[5]

OAT offers convenience for patients who have abandoned CPAP or just want an oral appliance. If they have verification of diagnosis from a physician, the dentist can provide oral appliance therapy – once again, this treatment needs to be communicated to the patients' physicians. Implementation of these services into a dental practice allows patients access to OAT with fewer appointments and allows the dentist to schedule more reliably and anticipate production.

The most desirable relationship for the dentist is to work with a board-certified sleep medicine physician (BCSMP) and an AASM Accredited Sleep Center. Historically, many dentists have enjoyed this relationship. The unfortunate reality is that although the number of qualified dentists is currently growing by approximately 400 dentists per year, the number of BCSMPs has decreased to approximately 5,500 in the United States. In many instances, multiple BCSMPs work at one AASM-accredited facility, so there are only about 2,600 AASM accredited facilities throughout the entire country.[6] Many accredited facilities are affiliated with hospitals, meaning they are in areas with higher populations; qualified dentists do not have the same geographic restrictions. In fact, there are currently more qualified dentists than AASM-accredited facilities in five states.

What all of this means is that there are more qualified dentists seeking opportunities to work with an AASM-accredited sleep center or BCSMP than opportunities that exist. This is especially true in less populated areas of the country. When it is not possible or when dentists want to expand their practice, it is perfectly fine to develop a referral relationship with one or more primary care physicians. These relationships can work to the benefit of both providers. Working with the patient's primary care physician ensures they are aware of the patient's treatment progress. Primary care physicians, who may not offer HSATs from their practice, may be eager to offer patients the local services you can provide if they are unhappy with the DME companies providing CPAP or do not have the bandwidth themselves to screen patients for sleep apnea. Dentists can and should accept referrals from primary care physicians of patients who may benefit from OAT. When working with a referral network, the more physicians with whom a relationship can be established, the better for all concerned.

Recommendation 4:

Control Costs - Consider taking steps to control the cost of the appliances selected for patients.

As mentioned previously, for those accepting reimbursement from insurers, oral appliances are considered DME and are often reimbursed as a global fee. For Medicare, all services provided from the initial evaluation to the 90-day follow-up examination, as well as the cost of the appliance and related laboratory services (impressions, digital scans, bite construction, etc.) are combined into a single fee. Reimbursement for the oral appliance is the same no matter the appliance prescribed. Laboratory fees and other related expenses increase from time to time, but reimbursement rates have stayed the same or have decreased. Because the reimbursement rate is constant or declining, the added expenses must be absorbed by the dentist.

It is also Important to keep in mind that patients, regardless of insurance, are mostly paying out-of-pocket for oral appliances. When deciding whether to move forward with an oral appliance, patients will factor all other options such as skipping the appliance altogether, trying a non-custom appliance, or considering CPAP or some other treatment that may be covered by insurance when deciding whether they can afford an oral appliance.

When dentists consider fee structure they are encouraged to take steps, as any business must, to control costs to ensure that OAT can be offered while providing the best patient care possible. One often overlooked expense is the cost of the appliance. When selecting an appliance for a patient, dentists must be mindful to select the most appropriate appliance based on the patient's needs and the proven effectiveness of the device. It is also appropriate to consider the patient's financial resources. For the most part, appliances work in similar fashion no matter the cost, trendy color, sleek new design, or other "cosmetic" factors. So, it can be ok to be cost conscious when selecting an appliance. For this reason, dentists need to take a stand on the prices they are paying for appliances. Some dentists set a "not to exceed" cost for an appliance, which is an approach that should be considered by all dentists. Others advocate for discounts based on volume discounts or laboratory relationships. The objective of providing OAT is to improve quality of sleep and overall health. Offering a treatment that is unaffordable is not achieving that objective.

CONCLUSION

The field of DSM is evolving. There is not a one-size-fits-all model for DSM practices. Each practice is reflective of what works best for the patients, referring physicians, and dentists in a community. Hopefully, this article has stimulated the reader to consider new options that address some common barriers. It is hoped that DSM practices remain viable and even flourish – there are 54 million Americans depending on it.

CITATION

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Address correspondence to: Jerome Barrett; E-mail: barrett7205@proton.me

DISCLOSURE STATEMENT

Mr. Barrett provides paid consultancy to the AADSM Board of Directors on various strategic efforts and initiatives. The opinions expressed in this article are solely his opinions and not endorsed by the AADSM.