Dental Sleep Medicine Implementation Toolkit

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"Cheat Sheet"

Obstructive Sleep Apnea: "OSA"

AHI
- Mild: 5-15
- Moderate: 15-30
- Severe: >30

Complete cessation of airflow for at least 10 seconds with 5 events per hour.

What is Apnea?

Apnea is a decrease in airflow by 90-100% for at least 10 seconds.

What is Hypopnea?

Hypopnea is a decrease in airflow of at least 30% for at least 10 seconds, with a 4% oxygen desaturation or an arousal.

What is a RERA?

RERA, Respiratory Effort Related Arousal, is an abnormal respiratory event associated with an arousal but without oxygen desaturation, thus does not meet the criteria of hypopnea.

What is AHI?

AHI is the total number of apneas added to the number of hypopneas to get the AHI number to determine the severity of the OSA (must have desaturation of O2 level).

What is RDI?

RDI is short for Respiratory Disturbance Index <30 % O2 desaturation. AHI + RERA's = RDI. Must have at least 5 events per hour.

What is an Arousal?

An **arousal** is an interruption of sleep lasting 3 to 15 seconds. It can occur spontaneously or as a result of sleep-disordered breathing or other sleep disorders. Each arousal sends you back to a lighter stage of sleep. If the arousal last more than 15 seconds, it becomes an awakening.

What is O2 Nadir?

The lowest point of oxygen saturation during a sleep study.

SAL: SLEEP ACRONYM LIST

ACRONYMS OF DENTAL SLEEP MEDICINE

AI	Apnea Index
AHI	Apnea Hypopnea Index
RDI	Respiratory Disturbance Index
RERA	Respiratory Effort Related Arousal
ODI	Oxygen Desaturation Index
OSA	Obstructive Sleep Apnea
UARS	Upper Airway Resistance Syndrome
OAT	Oral Appliance Therapy
OA	Oral Appliance
MAD	Mandibular Advancement Device
MAP	Mandibular Advancement Appliance
MRD	Mandibular Repositioning Device
MRA	Mandibular Repositioning Appliance
MOS	Mandibular/Maxillary Occlusal Splint
SRDB	Sleep Related Breathing Disorder
SB	Sleep Bruxism
GERD	Gastroesophageal Reflux Disease
RLS	Restless Leg Syndrome
PLMD	Periodic Leg Movement Disorder
ESS	Epworth Sleepiness Scale
EDS	Excessive Daytime Sleepiness
RES	Residual Excessive Sleepiness
REM	Rapid Eye Movement
RMMA	Rhythmic Masticatory Muscle Activity
CPAP	Continuous Positive Air Pressure
COPD	Chronic Obstructive Pulmonary Disease
CBT	Cognitive Behavioral Therapy
ED	Endothelial Dysfunction/Erectile Dysfunction
DME	Durable Medical Equipment
HPA	Hypothalamic-Pituitary-Adrenal Axis
CAD	Coronary Artery Disease
CHF	Chronic Heart Failure
LVH	Left Ventricle Hypertrophy
IH	Intermittent Hypoxia
CIH	Chronic Intermittent Hypoxia
LOA	Lapse of Attention
RAS	Reticular Activation System
SCN	Superchiasmatic Nucleus
RBD	REM Behavior Disorder
HST	Home Sleep Test
PAT	Peripheral Arterial Tonometry
BMI	Body Mass Index
ANC	Adjusted Neck Circumference
ROM	Range of Motion
MMA	Maxillomandibular Advancement
QOL	Quality of Life
RCMP	Remote Controlled Mandibular Positioner
LSAT	Lowest 02 Level (Nadir)
OHS	Obesity Hypoventilation Syndrome
LOMN	Letter of Medical Necessity
MSLT	Multiple Sleep Latency Test
SWS	Slow Wave Sleep
TST	Total Sleep Time
WASO	Wake After Sleep Onset
PE	Protrusion Element
SRI	Stackable Receptacle Insert
RCI	Remote Control Insert
PMH	Past Medical History
SAR	Seasonal Allergic Rhinitis
HSAT	Home Sleep Apnea Test

New Sleep Patient: Medical Insurance Verification Form Date_____ Staff Initial ____

Patient Name _____DOB _____Referred by_____
Primary MD _____ DDS_____
Patient: Home# _____Cell# _____ Email_____
Patient Home Address: _____
Other Drs:_____

Sleep History:

PSG/HSAT? Y/N Date: _____, Do you use CPAP? Y/N, Intolerant to CPAP? Y/N, Returned CPAP? Y/N Date _____, Chief Complaint(s) _____

Dental History:

Last Dental Visit: _____ Invisalign/Braces? Y/ N, Do you have Dentures or Implant Dentures? Y/N, Are you currently undergoing dental Tx? N/Y _____

Medical Insurance Information:

Medical Insurance Name_____ Patient ID # _____
Patient SS#_____/_____/_____ Insurance Phone Number _____
Patient Primary Insurance holder? Y/N If No - Primary Relation: _____
Primary Name _____ Primary DOB _____ Primary SS# ____/_____/_____

Verification of Benefits:

Ins Rep_____ Date ____Time ____Call Ref# _____
Are we In-Network? Y/N, Out-of-Network Benefits? Y/N, Requested one of the following:
Single Case Agreement / One Time Network Exception / Gap Waiver / In for Out
Effective Date: Calendar Year: Y / N _____

99244 (Office Visit Level 4) Ded. Applies: Y/N | Pre A, D, C: Y/N Co-pay: _____ Co-ins: _____	70486 (CT Both Arches) Ded. Applies: Y/N | Pre A, D, C: Y/N Co-pay: _____ Co-ins: _____
70355 (Pano) Ded. Applies: Y/N | Pre A, D, C: Y/N Co-pay: _____ Co-ins: _____	E0486 (Custom Oral Appliance Diag G47.33) | Pre A, D, C: Y/N Ded. Applies: Y/N Co-pay: _____ Co-ins: _____
95800 (WatchPat) Ded. Applies: Y/N | Pre A, D, C: Y/N Co-pay: _____ Co-ins: _____	Additional Notes:

Deductible: Ind_____Fam_____Met Yes/No Out Pocket Max: Ind_____Fam_____Met Yes/No

Pre-Authorization:

Code: _____ Pre-Auth Dept. Phone/Fax# _____ Pre Auth #_____
Pre-Auth Rep: _____ Call Reference #_____
Code: _____ Pre-Auth Dept. Phone/Fax# _____ Pre Auth #_____
Pre-Auth Rep: _____ Call Reference # _____
Frequency Limit:_____ Notes: _____
_____
_____

Dental Health & Wellness of Long Island

ADVANCING HEALTH THROUGH DENTISTRY

Dear Lewis, August 6, 2021

It was a pleasure speaking with you today and we look forward to meeting you soon. So that we can expedite your registration process and prepare for your initial visit, **please complete the three items below.**

1-Please send us a copy of your license and insurance card (front and back) which will enable us to begin verification of your insurance benefits.

2-Please click the link below to complete your medical history and sleep questionnaire.

History Exam Workup

3-Please open the two links below and complete our dental history and patient registration forms. (Return via email, or regular mail)

Medical History

Patient Registration

Additionally, to help you navigate through the process of getting your oral appliance, we have developed a "*Patient Manual for Obstructive Sleep Apnea"***.** We encourage you to stop by and pick this up prior to your first visit.

Completion of your paperwork is required 24 hours prior to your first visit, and is considered as confirmation for this appointment.

We are here to help you. If you have any questions, please let us know. Thank you for choosing us for your Dental Health and Wellness needs.

Melissa Licari

Dental Sleep Medicine & Airway Patient Coordinator

Dental Health and Wellness of Long Island

Steven Lamberg D.D.S., DABDSM

140 Main Street, Northport NY 11768

Phone: 631-261-6014 Fax: 631-261-6364

North Shore Snoring and Sleep Apnea Dental Treatment Center

Steven Lamberg, D.D.S, P.C.
140 Main Street
Northport, NY 11731
(631) 261-6014- Fax (631) 261-6364
stevenlambergdds@gmail.com
www.LambergSleepWell.com

REQUEST FOR RELEASE OF DENTAL X-RAY RECORDS

To:_____

Fax: Phone:

Dear Doctor. Our mutual patient will be seeing Dr. Lamberg for treatment of Obstructive Sleep Apnea. To confirm that they are a good candidate for this treatment, I am requesting copies of: **Current Dental X-RAY Records (Bite Wings, FMS, PA's or Pano within the last 18 months)**

Date:_____

Patient Name: _____

Patient D.O.B: _____

Patient Signature: _____via phone_____

Please forward to the email or address above.

Thank you.

~Dr. Steven Lamberg

~Leslie Kilgour – Dental Sleep Medicine Patient Coordinator

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Diplomate of the Academy of Clinical Sleep Disorders Disciplines
Author: Treat the Cause...Treat the Airway

Facsimile Transmittal Sheet

To:	Dr. Shareeff, MD	**From:**	Dr. Lamberg/ Melissa
Phone:	631-815-3400	**Pages:**	2 including cover page
Fax:	631-815-3401	**Date:**	10/08/2021
Re:	SOAP NOTES, LOMN & RX	**Patient:**	William S. O'Brien DOB 08/06/1934

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

1. The above patient has been referred to see Dr. Steven B. Lamberg for an oral appliance for obstructive sleep apnea. Please forward his most recent baseline PSG.
2. Please send a letter of medical necessity with a diagnosis of **Obstructive Sleep Apnea G47.33** with **Custom Oral Appliance E0486** as treatment to our office (see the sample attached)
3. For insurance reimbursement reasons, your most recent **chart notes before and after the sleep study,** that include any diagnosis of comorbidities related to sleep apnea, will be helpful.

Thank you,

Melissa

July 12, 2024

SAMPLE:

Letter of Medical Necessity Template for referring doctor for request of oral appliance

ON YOUR LETTER HEAD

Date

Steven Lamberg DDS
140 Main Street
Northport, NY 11768

Re: **Patient's name and DOB**

Dear Dr. Lamberg,

Patient's name, has recently had an overnight sleep study performed by **name of sleep center** on **date**. The baseline study reveals an increased respiratory disturbance index (RDI) of _____which is consistent with **(*mild/moderate/severe)** apnea, diagnosis code G47.33.

I have recommended that the patient be evaluated for an oral appliance for the treatment of **(*mild/moderate/severe)** sleep apnea (E0486). (***Mild** cases require a **comorbidity**) This patient has a comorbidity of _____.

Medical Justification:

(**Alert** Due to recent issues with insurance coverage we strongly advise you to include one of the following sentences in your letter of medical necessity)

A) This patient has been using CPAP for an adequate amount of time to fairly assess based on the attached compliance reports that he/she is unable to tolerate this modality of treatment.

Or

B) After a lengthy discussion, we have established the patient's inability to attempt the use of CPAP based on documented psychological and/or physical constraints.

Due to the above noted history and physical information, I am recommending an Oral Appliance (E0486) for the treatment of this patient. I, the undersigned, certify the above prescribed procedure is medically necessary in the treatment of the diagnosis. This signed document is to serve as both a prescription for the oral appliance therapy and the letter for this medical necessity.

Thank you.

Sincerely,

Sign your name here (Please have MD sign)

Mild: 5-15 Moderate: 15-30
Severe: >30

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Diplomate of the Academy of Clinical Sleep Disorders Disciplines
Author: Treat the Cause...Treat the Airway

To:	Dr Schmitz	**From:**	Dr. Lamberg/Jeana
Phone:		**Pages:**	2
Fax:	631 6285200	**Date:**	1/4/21
Re:	RX, & Letter of Medical Necessity	**Patient:**	Earl Matchett DOB 7/7/36

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Dear Dr Matchett ,

Our mutual patient would like to continue to be seen by Dr. Steven B. Lamberg for his obstructive sleep apnea.

He has been successfully using the oral appliance. Since the patient requires a new appliance after normal wear and tear from regular use, kindly please forward our office an updated letter of medical necessity (please see the sample attached) for diagnosis of Obstructive Sleep Apnea G47.33 with Custom Oral Appliance E0486 as treatment. Also, an Rx with G47.33 as the diagnosis code and E0486 as treatment.

Please send a copy of the most recent baseline PSG. We are also able to offer the patient an HSAT if needed.

Thank you!

July 12, 2024

-

EXAMPLE Letter of Medical Necessity Template for referring doctor for request of oral appliance

ON YOUR LETTER HEAD

Date

Steven Lamberg DDS
140 Main Street
Northport, NY 11768

Re: **Patient's name and DOB**

Dear Dr. Lamberg,

Patient's name, has recently had an overnight sleep study performed by **name of sleep center** on **date**. The baseline study reveals an increased respiratory disturbance index (RDI) of _____which is consistent with **(*mild/moderate/severe)** apnea, diagnosis code G47.33.

I have recommended that the patient be evaluated for an oral appliance for the treatment of **(*mild/moderate/severe)** sleep apnea. (***Mild** cases require a **comorbidity**) This patient has a comorbidity of _____.

(**Alert** Due to recent issues with insurance coverage we strongly advise you to include one of the following sentences in your letter of medical necessity)

A) This patient has been using CPAP for an adequate amount of time to fairly assess based on the attached compliance reports that he/she is unable to tolerate this modality of treatment.

Or

B) After a lengthy discussion, we have established the patient's inability to attempt the use of CPAP based on documented psychological and/or physical constraints.

Thank you.

Sincerely,

Sign your name here

Mild: 5-15
Moderate: 15-30
Severe: >30

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Diplomate of the Academy of Clinical Sleep Disorders Disciplines
Author: Treat the Cause...Treat the Airway

Dear Dr. , (Date)

We recently saw (patient name), who you recommended to our office. I wanted to personally thank you for the confidence you have shown in us by your continued referrals.

After our data collection is complete, we will make any necessary referrals and keep you informed of the status of our mutual patient.

We understand OSA is a condition the patient will need to have monitored for the rest of their lives, and we are committed to following up with them on a regular basis to optimize their treatment success.

Warm personal regards,

Dr. Steven Lamberg, DDS, DABSDM

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Steven Lamberg, D.D.S., Diplomate AADSM
Diplomate of the Academy of Clinical Sleep Disorders Disciplines
Author: Treat the Cause...Treat the Airway

10/24/2023

The Gelb Center
Dr. Michael Gelb
635 Madison Avenue
New York, NY 10022

RE: Jon Nierman
221 N Old Dixie Hwy #5
Tequesta, FL 11731
DOB: 05/20/1988 Insurance ID#: 1234-567-890

Dear Dr. Michael Gelb,
We delivered an oral appliance (OA) to _____(patient name) on ____(date). After 3 months of calibrating the appliance and receiving positive subjective reporting from the patient, we administered a HSAT with the Watch PAT 300 on _____(date). The study was scored using the _____(3% or 4%) rule.

This study revealed a reduction in the AHI from the _____(date) baseline study of ____ to ____ while wearing the OA.
The RDI as also been reduced from a baseline of _____ to _____.

The ODI has been reduced from a baseline of ____ to _____.
The O2 nadir has been raised from a baseline of ____% to ___%.
The T<90% O2 has been reduced from a baseline of ____% to ____% while using the appliance.

REM sleep has been increased from a baseline of ____% to ___%.
SWS at has been increased from a baseline of ___ % to ____%.

The patient reports that wearing the OA at its current degree of protrusion is sustainable.

We have made the following recommendations:_____.

I have referred the patient back to your office for a consultation regarding assessment of the _____(date)HSAT and the patient's overall health. We will continue
to monitor the patient as well as the condition of the appliance at yearly intervals going forward.

Thank you very much for the confidence you have shown in me by referring your patients here. If you have any questions please
call at any time.

Sincerely yours,

Steven Lamberg DDS, DABDSM

Lamberg Airway & Sleep Navigator V22

Exam Date ___ /___/___ Consult For: Snoring ____ UARS ____ OSA ____ EDS ____

Pt Name _____ Pt. DOB ___ /___ / ___ Address _____
Pt Cell # _____ Home # _____ Email: _____
Referred by _____ Dentist _____ Phone _____
Primary MD/Specialty _____ Phone _____
Other Specialists _____
_____

PRE-CLINICAL STATUS

Chief Complaint(s): Insomnia _____, Snoring & Apneas _____, EDS _____, Other _____

Baseline Studies:

PSG/HSAT (3%/4%) ____/____/____ RDI ____, AHI ____, ODI ____, O2 Nadir ____%, T<90% ____%, REM ____%, SWS ____%
PSG/HSAT (3%/4%) ____/____/____ RDI ____, AHI ____, ODI ____, O2 Nadir ____%, T<90% ____%, REM ____%, SWS ____%
OSA: (Mild - Mod - Severe) CPAP Rx Y/N, ___cm H20 (Refused ___, Intolerant ___), ESS ___, LQ ___, NOSE ___, MyoQ ___, FSS ___, ISI ___
Medications: _____
_____

Co-morbidities:

	Y	N		Y	N		Y	N
Nasal Obstruction	☐	☐	Diabetes, Insulin Resistance	☐	☐	Alzheimer's or Dementia	☐	☐
Postnasal Drip	☐	☐	Gout	☐	☐	Excess Dental Attrition	☐	☐
Hypertension	☐	☐	Leg Cramps, Dizziness	☐	☐	Glaucoma	☐	☐
Elevated Cholesterol	☐	☐	Night Sweats	☐	☐	Chronic Pain/Headaches	☐	☐
CVD	☐	☐	RLS/PLMs	☐	☐	Cancer	☐	☐
AFib	☐	☐	Glaucoma	☐	☐	NAFLD	☐	☐
CHF	☐	☐	Fibromyalgia	☐	☐	Arthritis	☐	☐
Hx Stroke/Heart Attack	☐	☐	Erectile Dysfunction/	☐	☐	Autoimmune Disease	☐	☐
Polycythemia	☐	☐	Low Testosterone			Dermatitis	☐	☐
COPD	☐	☐	Pregnancy	☐	☐	Insomnia	☐	☐
Asthma	☐	☐	Nocturia	☐	☐	Excessive Daytime Sleepiness	☐	☐
Pulmonary HTN	☐	☐	Menopause	☐	☐	Snoring	☐	☐
TMD	☐	☐	Kidney Disease	☐	☐	Other_____	☐	☐
GERD	☐	☐	Memory Problems	☐	☐	_____		

TREATMENT LOG

Referrals: _____

Dental Tx is OAT Prereq. Y/N _____ AP-ROM ____, Initial Protrusion ____

Appliance Selected _____, Lab _____, Scan ___/___/___ OA Delivery ___/___/___, Pt Manual Dispensed ☐

Follow-Ups:	Week 1: ___/___/___	Month 1: ___/___/___	Month 2: ___/___/___	Month 3: ___/___/___
Ess: Pre ___	_____	_____	_____	_____
Comments:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Side Effects:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Adjustments:	_____	_____	_____	_____

Calibration Studies

Date: ___/___/___
HSAT (3%/4%) RDI ____, AHI ____, ODI ____, O2 Nadir ____%, REM ____%, SWS ____%, T<90% ________
Puls Ox _______, El _______, AI _______, ODI _______, O2 Nadir _______%

Date: ___/___/___
HSAT (3%/4%) RDI ____, AHI ____, ODI ____, O2 Nadir ____%, REM ____%, SWS ____%, T<90% ________
Puls Ox _______, El _______, AI _______, ODI _______, O2 Nadir _______%

Date: ___/___/___
HSAT (3%/4%) RDI ____, AHI ____, ODI ____, O2 Nadir ____%, REM ____%, SWS ____%, T<90% ________
Puls Ox _______, El _______, AI _______, ODI _______, O2 Nadir _______%

Follow-Up Baseline Studies

Date: ___/___/___
HSAT (3%/4%) RDI ____, AHI ____, ODI ____, O2 Nadir ____%, REM ____%, SWS ____%, T<90% ________
Puls Ox _______, El _______, AI _______, ODI _______, O2 Nadir _______%

Date: ___/___/___
HSAT (3%/4%) RDI ____, AHI ____, ODI ____, O2 Nadir ____%, REM ____%, SWS ____%, T<90% ________
Puls Ox _______, El _______, AI _______, ODI _______, O2 Nadir _______%

OAT Maintenance Log

	Month 6 ___/___/___	Year 1 ___/___/___	Year 2 ___/___/___	Year 3 ___/___/___	Year 4 ___/___/___	Year 5 ___/___/___
Comments						
Side Effects						
Adjustments						
Condition of Appliance						
Additional Notes						

Lamberg Airway and Sleep: Data Collection & Referrals V7

☐ Cardiologist ☐ Dentist ☐ Dietician ☐ Otolaryngologist ☐ Pulmonologist

☐ Orthodontist/Oral Surgeon ☐ Oral Myologist ☐ Neurologist ☐ Psychologist

Name: _____ DOB: _____ Date: _____ Chief Complaint: _____

VITAL SIGNS +

	Y	N
Blood Pressure High ___/___	☐	☐
Heart Rate High ___/___	☐	☐
NHR: N/H ≥ .21	☐	☐
Waist/Height > .55	☐	☐
CVD Red Flags	☐	☐

Neck _____

Waist _____

Height _____

Weight _____

	Y	N
Chronic Pain	☐	☐
BMI > 30 _____	☐	☐
Rx Oral DNA (Bleeding on Probing)	☐	☐
Rx Comprehensive Dental Exam	☐	☐
Insomnia	☐	☐

STRUCTURE (Anatomic)

Clinical:

	Y	N
Tonsils Brodsky Grade 3 - 4	☐	☐
PNIF < 100 l/m _____	☐	☐
Cottle Maneuver +	☐	☐
Enlarged Uvula	☐	☐
Allergic Shiners	☐	☐
Dennie-Morgan Lines	☐	☐
FEV1 < 80% _____	☐	☐

	Y	N
TMJ: Load Test +, Muscle Test +	☐	☐
Excess Wear, Recession, NCCLs	☐	☐
Erosion	☐	☐
More than 8 Missing Teeth	☐	☐
Tongue Overflow Max Arch	☐	☐
Scalloped Tongue	☐	☐
Enlarged Sclera	☐	☐

	Y	N
Friedman Tongue Posture 3 - 4	☐	☐
Mallampati Grade 3 - 4	☐	☐
TRM MOTIP/MIO < 50%	☐	☐
Gingival Display > 4mm _____	☐	☐
Mew Indicator Line > 44mm ___	☐	☐
Cricomental Space < 1.5cm	☐	☐
Tori Max/Mand	☐	☐

Ceph:

	Y	N
SNA < 79° Deficient Maxilla	☐	☐
SNB < 76° Deficient Mandible	☐	☐
FH-MP > 27° Excess Vertical Growth	☐	☐

	Y	N
ANB > 5° Skeletal Class 2	☐	☐
ANB < 1° Skeletal Class 3	☐	☐
PV-A Line < 97mm Retrognathic Maxilla	☐	☐

	Y	N
Anterior Open Bite	☐	☐
Other Craniofacial Deficiencies:	☐	☐
_____		

CBCT:

	Y	N
MP-H > 15mm _____	☐	☐
MinXA < 110mm _____	☐	☐
Intermolar Distance < 38mm ___ (between max 1st molars)	☐	☐
Intermolar Distance < 24mm+age (between primary 2nd molars <6 years)	☐	☐

	Y	N
Intercuspid Distance < 29mm ___	☐	☐
PHI (H/W x 100) > 42% _____	☐	☐
Dental Crowding	☐	☐
Mucosal Thickening in Max Sinus	☐	☐
Hypertrophied Turbinates	☐	☐

	Y	N
Deviated Septum _____	☐	☐
Septal Spur	☐	☐
Enlarged Swell Body	☐	☐
Concha Bullosa	☐	☐
Adenoids Enlarged	☐	☐

FUNCTION (Physiologic)

	Y	N
PCrit High	☐	☐
ArTH Low	☐	☐

	Y	N
Loop Gain High	☐	☐

	Y	N
Dialator Muscle Response Low	☐	☐

BEHAVIOR A (Habits)

	Y	N
Mouth Breathing	☐	☐
Forward Head Posture	☐	☐

	Y	N
Chest Breathing	☐	☐

	Y	N
Low Tongue Resting Posture	☐	☐

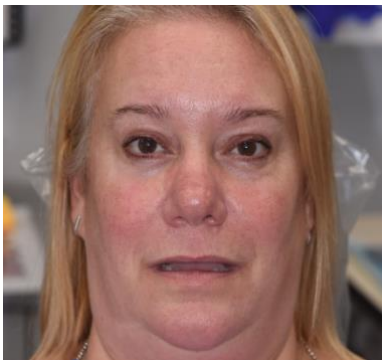
BEHAVIOR B (Muscle Fuction)

	Y	N
Lip Incompetence	☐	☐
Snoring (Palatal Flutter)	☐	☐

	Y	N
Swallow Accompanied by Tongue Thrust	☐	☐

	Y	N
Overactive Perioral Musc. (incl. Mentalis) on Swallow or Lip Closure	☐	☐

Lamberg Airway Photography



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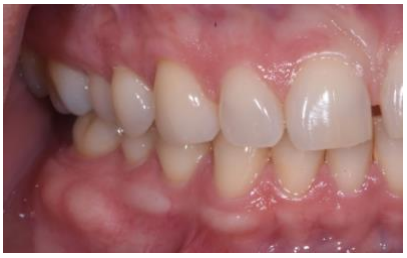

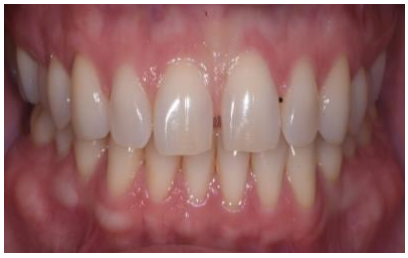

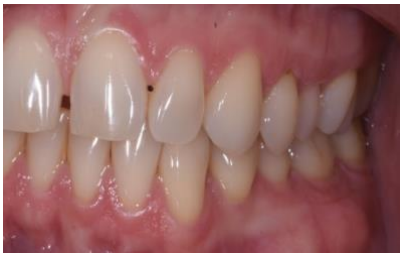

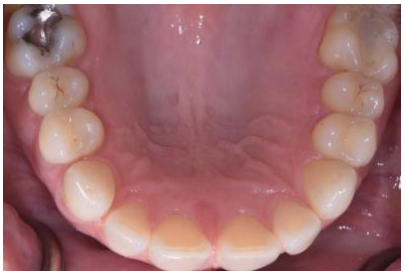

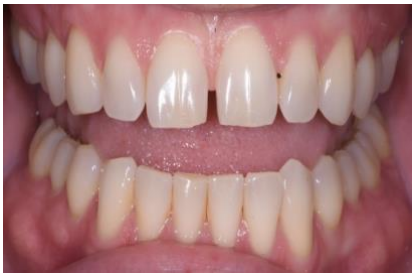

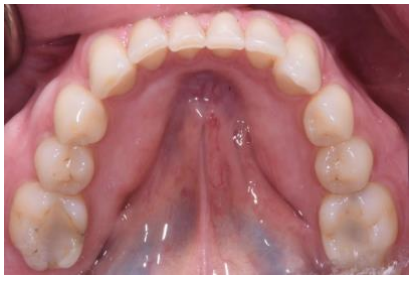

LAMBERG QUESTIONNAIRE Version 16

Associating Snoring and Sleep Apnea with Health

www.drlamberg.com

1: TRADITIONAL SCREENING QUESTIONS

- ☐ Do you awaken unrefreshed or feel sleepy during the day due to restless sleep?
- ☐ Is your snoring loud enough to disturb others?
- ☐ Have you been aware of your snoring for a long time?
- ☐ Have you been told your breathing stops while asleep?
- ☐ Do you ever wake yourself from sleep feeling that you are choking?
- ☐ Have you ever had a sleep study?
- ☐ Have you tried CPAP? (Was the pressure > 10.5 cm? Y/N)
- ☐ Is your BMI > 27? Is your neck > 17" for a man, or > 15.5" for a woman?
- ☐ Do the edges of your tongue have a scalloped pattern?
- ☐ Is your waist/height > .55?

2: CARDIOLOGY & VASCULAR MEDICINE

- ☐ Do you have high blood pressure or take medicine for hypertension?
- ☐ Have you been diagnosed with CAD, stroke, congestive heart failure, Afib, other heart health issues, or syncope?
- ☐ Do you have a pacemaker?
- ☐ Do you have elevated total cholesterol levels?

3: PULMONOLOGY

- ☐ Have you experienced difficulty breathing during the day?
- ☐ Do you have shortness of breath, even with mild exertion?
- ☐ Have you been diagnosed with COPD, asthma, or pulmonary hypertension?
- ☐ Is asthma worse at night?
- ☐ Do you have a chronic cough, either dry or productive?

4: GASTROENTEROLOGY

- ☐ Have you or your dentist noticed erosion on molars?
- ☐ Do you experience heartburn or acid reflux at night or when you awaken in the morning?
- ☐ Do you take heartburn medications, either prescription or OTC?

5: NEUROLOGY

- ☐ Do you experience numbness, tingling or pain in your feet or hands or head?
- ☐ Do you ever experience leg cramps at night?
- ☐ Do you ever experience muscle weakness or dizziness or difficulty with coordination?
- ☐ Have you ever been diagnosed with Alzheimer's or dementia?

6: ENDOCRINOLOGY

- ☐ Have you been diagnosed with diabetes or hypothyroidism?
- ☐ Have you unexpectedly gained or lost weight lately?
- ☐ Have you gone through menopause? Are you on HRT?
- ☐ Have you been diagnosed with low testosterone?
- ☐ Do you experience repetitive limb movements or jerks in sleep, urges to move legs, night sweats, or leg cramps?

7: OTOLARYNGOLOGY

- ☐ Do you have difficulty breathing through your nose?
- ☐ Do you experience a dry mouth upon awakening?
- ☐ Do you have allergies that make nasal breathing difficult?
- ☐ Is postnasal drip a frequent problem?

8: UROLOGY

- ☐ Do you experience erectile dysfunction?
- ☐ Do you experience decreased interest in sex or have you taken medications to enhance sexual performance?
- ☐ Do you ever leak urine involuntarily?
- ☐ Do you have to urinate several times at night, or have you been diagnosed with BPH?

9: DENTISTRY

- ☐ Do you grind your teeth while sleeping?
- ☐ Do your front teeth have a worn look?
- ☐ Have you had jaw muscles or joint pain, ringing in your ears, vertigo, or dizziness?
- ☐ Have you been diagnosed with periodontitis (gum disease)?
- ☐ Are your teeth crowded or crooked or jaws misaligned?

10: PSYCHOLOGY & PSYCHIATRY

- ☐ Are you irritable upon waking in the morning?
- ☐ Do you experience insomnia? (falling asleep or maintaining sleep)
- ☐ Do you experience depression, anxiety, PTSD, memory or concentration problems?
- ☐ Do you take medications for any of these conditions?

11: RHEUMATOLOGY

- ☐ Have you ever been diagnosed with gout?
- ☐ Have you ever been diagnosed with rheumatoid arthritis?

12: DERMATOLOGY

- ☐ Have you been diagnosed with atopic dermatitis (eczema) or psoriasis?

13: OPHTHALMOLOGY

- ☐ Have you been diagnosed with floppy eyelid syndrome, chronic eye irritation, dry eye syndrome, glaucoma, nonarteritic anterior ischemic optic neuropathy, papilledema, keratoconus, central serous chorioretinopathy, or macular edema?
- ☐ Are you taking antivascular endothelial growth factor medications for retinal disease?

14: CHRONIC PAIN

- ☐ Do you often wake up with headaches or have chronic headaches?
- ☐ Do you experience any chronic pain anywhere in your body?
- ☐ Do you take medications for pain on a daily basis?

15: HEPATOLOGY

- ☐ Have you ever been diagnosed with nonalcoholic fatty liver disease?

16: ONCOLOGY

- ☐ Have you ever been diagnosed with cancer?

17: OBSTETRICS (GESTATIONAL OSA)

- ☐ In prepregnancy: Are you 35 or older or is your BMI>25?
- ☐ Do you feel fatigued, experience nasal congestion, or have you started to snore?
- ☐ Has your BP or blood sugar increased significantly?

18: NEPHROLOGY

- ☐ Have you been diagnosed with kidney disease?

19: PEDIATRICS (EXCLUDE FROM SCORING)

- ☐ Do you know any children who are mouth breathers, have large tonsils, or who make any sleep breathing sounds?
- ☐ Do you know any children with bedwetting problems?
- ☐ Do these children have a crossbite or convex facial profile?

Risk level of having a sleep-related breathing disorder: 1 LOW 2-3 MODERATE 4+ HIGH

Name: _____ DOB: _____ Date:_____ Score: _____ 

Lamberg Questionnaire for Pediatric Airway and Sleep
"LQ-PAS"

A Risk Assessment Tool for Pediatric Airway and Sleep

Patient Name/DOB: _____ Date: _____

	Yes	No	Don't Know
While sleeping, does your child…			
have trouble breathing or struggle to breath?			
stop breathing during the night?			
have "heavy" or loud breathing?			
snore regularly?			
snore loudly?			
snore more than half the time?			
appear to be a restless sleeper?			
child kick during sleep?			
have nightmares?			
scream in their sleep?			
grind their teeth during sleep?			
sleepwalk?			
occasionally wet the bed?			
Upon awakening, does your child…			
have a dry mouth in the morning?			
tend to breathe through the mouth during the day?			
wake up feeling un-refreshed in the morning?			
have a problem with sleepiness during the day?			
have trouble getting going in the morning?			
wake up with headaches in the morning?			
We have noticed that our child…			
does not seem to listen when spoken to directly			
has difficulty organizing tasks			
is easily distracted by extraneous stimuli			
fidgets with hands or feet or squirms in seat			
interrupts or intrudes on others (e.g. butts into conversations or games)			
has a teacher or other supervisor comment that your child appears sleepy during the day			
has been diagnosed with ADD or ADHD			
Additionally…			
did your child stop growing at a normal rate at any time since birth?			
is your child overweight?			
does your child's teeth seem crooked or misaligned?			
does your child have allergies?			
does your child have frequent colds?			
does your child have difficulty with pronunciation?			

"ARFs" (Airway Red Flags)

For Physicians Use Only

(Check all that apply)

Signs		Symptoms
___Lips apart at rest (open mouth posture)	___Speech problems	___Difficulties breastfeeding
___Mouth breathing	___Poor eating and swallowing	___Dysphagia
___Lip Incompetence	___Parafunctional habits	___Snoring
___Lip strain when lips together	___Lower jaw set further back than upper jaw (Underbite)	___Tooth grinding
___Swollen adenoids and tonsils	___Eye shiners (dark circles under the eyes)	___Coughs, Colds, and Chest infections
___Forward Tongue Resting Posture	___Bags under eyes	___Chronic allergies
___Tethered Oral Tissues	___Scalloped tongue	___Nasal Congestion
___Restricted Lingual Frenulim	___Arrested growth	___Snoring and fatigue
___High Narrow Palate	___Poor Facial Symmetry	___Asthma symptoms
___Crusty and dry lips and or mouth	___Narrow Posterior Airway Space (on ceph)	___Cognitive communication deficits
___Narrow smile	___Nasal Resistance (CBCT)	___Poor academic performance
___Long Face Height	___Vertical Position of the Hyoid (should be C4, higher or lower not good) Ceph or CBCT	___Language delays
___Flattened Cheeks	___Other _____	___Frequent headaches
___Maxilla retruded	_____	___Frequent nightmares
___Weak Chin (lower jaw retruded)	_____	___Bed Wetting
___Crowded/Crooked teeth		___Child behavioral disorders
___Crossbite and open bite malocclusions		___Aggressive behavior
___Excessively worn teeth		___Irritability
___Gummy Smile		___Possible dx of ADD or ADHD
		___Restless Sleep

Pediatric Airway and Sleep Referral

Date: _____

Patient Name/DOB:_____ Physician: _____

Address:_____ Physician Phone: _____

Phone:_____ Physician Fax: _____

Specialty Evaluation Requested by: ENT, Allergist, Oral Surgeon, Orthodontist, Myofunctional Therapist, Speech/Language Therapist, Neurologist, Dietician, Pediatric Dentist, General Dentist, Psychologist, Sleep Specialist including (Initial consultation, Polysomnogram as necessary, and follow-up)

____ Overnight Attended Sleep Study/Polysomnogram

Reason for referral: _____

_____

Medical History and Pertinent Physical Exam Findings: _____

_____

_____

Dental Health and Wellness of Long Island
Oral Appliance Follow-Up V16

Epworth Sleepiness Scale "ESS":

How likely are you to doze off or fall asleep in the following situations?
Choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Activity	Wk. 1 _/_/_	Mo. 1 _/_/_	Mo. 2 _/_/_	Mo. 3 _/_/_	Mo. 6 _/_/_	Yr 1 _/_/_	Yr 2 _/_/_	Yr 3 _/_/_	Yr 4 _/_/_	Yr 5 _/_/_
Sitting and reading										
Watching TV										
Sitting, inactive in a public place (theater, meeting)										
As a passenger in a car for an hour without a break.										
Lying down to rest in afternoon when permitted										
Sitting and talking to someone										
Sitting quietly after lunch without alcohol										
In a car, while stopped for a few minutes in traffic										
TOTAL.....(original pre-tx score____)										

Appliance Experience Questionnaire "AEQ"

		Wk. 1 _/_/_	Mo. 1 _/_/_	Mo. 2 _/_/_	Mo. 3 _/_/_	Mo. 6 _/_/_	Yr 1 _/_/_	Yr 2 _/_/_	Yr 3 _/_/_	Yr 4 _/_/_	Yr 5 _/_/_
1. Blood Pressure.											
2. Weight.											
3. Nights per week wearing the appliance.											
4. Hours per night wearing the appliance.											
5. Number of awakenings per night.											
	(Least 0 - 10 Best)										
6. Chief Complaint: _____	0 1 2 3 4 5 6 7 8 9 10										
7. Comfort:	0 1 2 3 4 5 6 7 8 9 10										
8. Perceived Benefit:	0 1 2 3 4 5 6 7 8 9 10										
9. Snoring Reduced:	0 1 2 3 4 5 6 7 8 9 10										
10. Rested Upon Waking:	0 1 2 3 4 5 6 7 8 9 10										
11. Daytime Sleepiness Reduced:	0 1 2 3 4 5 6 7 8 9 10										
12. Ease of Care/Use:	0 1 2 3 4 5 6 7 8 9 10										
13. Questions Answered:	0 1 2 3 4 5 6 7 8 9 10										
14. Access to Office:	0 1 2 3 4 5 6 7 8 9 10										
15. Nasal Breathing	0 1 2 3 4 5 6 7 8 9 10										

16. Side Effects: Tooth Discomfort, Jaw Pain or Muscle Pain, Bite Problems, Other: (please date) _____

Patient Name _____ DOB ____/ ____/ ____

Dental Health & Wellness of Long Island
ADVANCING HEALTH THROUGH DENTISTRY

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Diplomate of the Academy of Clinical Sleep Disorders Disciplines

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Stevenlambergdds@gmail.com
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To:	**From:** Dr. Steven Lamberg/Leslie
Fax:	**Pages:**
Phone:	**Date:**
Re: – DOB	**Attn:** PRE-Determination and In-Network Exception Request E0486 70355 & 99204

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Dear Pre-D Department,

I am forwarding all the Medical Necessity documents for your review for a **Pre-Determination and In-Network Exception Request**. The patient is coming to see Dr. Steven Lamberg for Oral Appliance Therapy (E0486). There are usually no in-network doctors that can make the E0486 - The cost of the E0486 is $4,000. The Diagnosis Code is 327.23 Obstructive Sleep Apnea. The patient will also been seen for a visit 99204 - New Patient Consult/Airway Exam - The cost of this exam is $250. 70355 Diagnostic Panoramic X-Ray $150.

Attached is the Letter of Medical Necessity, Sleep Study and Affidavit of CPAP intolerance. Please do not hesitate to call me with any questions.

PATIENT ID # – DOB

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Steven Lamberg, D.D.S., Diplomate AADSM
Diplomate of the Academy of Clinical Sleep Disorders Disciplines
Author: Treat the Cause...Treat the Airway

July 12, 24

Dr. Robert Berg
150 East 69th Street
New York, New York 10021

Dear Dr. _____,

It was a pleasure meeting you. I wanted to give you a little information on our office and the Lamberg Sleep Well Appliance. First, we start with a thorough review of the medical history of each patient. The patient is educated about the pathophysiology of snoring and sleep apnea so they understand their problem. A complete examination of the airway is done and correlated with predictors of success for oral appliance therapy.

We record the range of motion of the lower jaw and determine the appropriate starting position.
We evaluate and communicate our expectations for the individual patient and forward a report to you.
After making impressions of the dental arches, we appoint the patient for delivery of the appliance.

Upon delivery, we make every effort to assure comfort so the appliance will be worn regularly.
Appointments are scheduled for: one week, one month, two month, three and six month follow-ups.
Follow-up visits are used to subjectively evaluate the status of the patient and titrate the appliance as necessary and validate our treatment position with the Itamar Watch-PAT home sleep test device before referring the patient back to the referring sleep MD for their final evaluation.

I would be happy to familiarize you with the Lamberg Sleepwell Appliance and the current protocols as set forth by the American Academy of Sleep Medicine and the American Academy of Dental Sleep Medicine.

Thank you again,

Steve Lamberg, DDS
Inventor of the Lamberg Sleep Well Device

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Steven Lamberg, D.D.S., Diplomate AADSM
Diplomate of the Academy of Clinical Sleep Disorders Disciplines
Author: Treat the Cause...Treat the Airway

Dear Dr. Cardiologist and primary care physician,

Thank you for sending us your contact information. We look forward to referring you our patients who need further assessment of their inflammatory status and heart attack and stroke risk.

Enclosed you will find an example of the ORAL DNA periodontal pathogen test that we use, as recommended by Dr. Brad Bale. We have been using this as part of the periodontal disinfection protocol that we use with great success. We look forward to collaborating with a physician, like you, who is trained to assist us in keeping our patients healthy by minimizing their heart attack and stroke risk.

Additionally, please find an informational piece on the Oral Appliance for the treatment of Obstructive Sleep Apnea that we provide to our patients when their physician recommends such therapy.

We look forward to working with you. If you need any more information, feel free to contact me personally.

Best regards,

Steven Lamberg DDS

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Dear Mr. Bonacasa,

The Snoring and Sleep Apnea Dental Treatment Center would like to thank you for choosing us. We are committed to you and your treatment. Please understand that payment of your bill is considered a part of your treatment. **This is only an estimate of your benefits, this bill does not guarantee coverage or payment by the insurance company. This is only a reflection of the information that was given to our office by your insurance company.** The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

This office will submit all claims to your insurance on your behalf for Oral Appliance Therapy. We should receive the payment from your insurance, however, in the unlikely event that your insurance company does not provide you with coverage for the E0486, **you will be financially responsible for $2,000 of the billable amount.**

Any checks forwarded to you by your insurance company are required to be redirected to this office for payment towards your account.

	Codes	**Fees billed to Insurance**
SLEEP CONSULTATION EXAM	99203	0
CONE BEAM CT SCAN	76012	0
ORAL APPLIANCE	E0486	$6,500.00
	Total billed to insurance:	**$6,500.00**

PAYMENT towards your bill:

- A payment of $235 will be due at the first visit for your Cone Bean CT Scan. You will be responsible for the balance of the payment listed on your EOB – Explanation Of Benefits. The insurance company will notify us of your financial responsibility on the EOB. The billed amount above is not the allowed amount. The allowed amount will be listed on the EOB.

Oral Appliance Therapy includes the oral appliance that Dr. Lamberg feels is best suited for you. All visits are covered for a period up to 3 months from delivery. (Initial Follow-up visit at **One Week.** Follow-up visits at: **One month, Two months, and Three months.)** One unattended **"take home"** sleep study, and any additional visits during this initial 3 month period, are covered with your appliance fee.

Any adjustments made to the appliance due to outside dental work (Not Dr. Lamberg) will be charged a **$79** fee. All periodic follow up visits will be scheduled at **6 Months, 12 Months, 24 Months, and 36 Months** from the delivery date. These visits will be charged at a fee of **$79** per visit and is due at the time of the visit. These visits will be filed with your insurance company. Depending on your insurance and your out-of-network benefit/deductible, these visits may not be covered by your insurance company. Any additional home sleep studies will be charged at **$100** per study. Your appliance is guaranteed for **3 years** against manufacturing defects. Repairs resulting from other causes will be charged our lab fee plus applicable office visit fees.

I have read, understand and agree to the policies as stated above.

Signature:_____Date:_____

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Informed Consent for the Treatment of Sleep Disordered Breathing

You have been diagnosed by your physician as requiring treatment for sleep-related breathing disorder (snoring and/or obstructive sleep apnea). Sleep apnea may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels, which in turn, may result in the following; excessive daytime sleepiness, driving and work related accidents, irregular heartbeats, high blood pressure, heart disease, stroke, obesity, diabetes, GERD, memory and learning problems, and depression.

What is Oral Appliance Therapy? Oral appliance therapy for snoring/obstructive sleep apnea attempts to assist your breathing during sleep by wearing a mandibular advancement device (MAD), in your mouth, to keep the tongue and jaw in a forward position, which keeps the airway open while wearing it. It also aims to decrease or alleviate snoring and help you sleep better.

Successful Treatment: Oral appliance therapy has effectively treated many patients. However, there are no guarantees that it will be effective for you, since everyone is different and there are many factors influencing the upper airway during sleep. The most important component of success is patient compliance. A recent article summarizing 87 studies, with over 2,000 patients, found a compliance rate of 77%. Based on various definitions of success and the patient's baseline severity, oral appliances appear to show success rates around 55% (Mild 81%, Moderate 60%, Severe 34%). It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time you may still experience the symptoms related to your sleep disordered breathing and precautions may apply.

Follow-up visits: Follow-up visits are required by our office at the following intervals (measured from your appliance delivery visit): 1 week, 1 month, 2 months, 3 months, 6 months, 1 year, and yearly thereafter to evaluate the success of your OSA treatment and your dental condition. Any decision on your part to forego follow-up appointments places your health at risk and increases the probability of complications and treatment failure. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Final Sleep Study and Evaluation: After your appliance is delivered, it will be adjusted by Dr. Lamberg for the best possible results. When your symptoms have improved and Dr. Lamberg is satisfied with the results of the adjustments, you will be referred back to your physician for a post-treatment sleep study. A post-treatment sleep study (PSG or Polysomnogram) is necessary to objectively assure effective treatment which must be reviewed by your physician, and you agree to have this follow-up study performed. Like sleep apnea, success of treatment can only be diagnosed by your physician. By signing this document, you hereby agree to follow Dr. Lamberg's instructions in detail. Failure to do so may result in a poor clinical outcome.

Side Effects and Complications of Oral Appliance Therapy: OSA is an unusual disease because it has been associated with many comorbid medical conditions if untreated: coronary artery coronary artery disease, high blood pressure, diabetes, cerebrovascular disease, stroke, heart problems, heart attack, atrial fibrillation, depression, mood disorders, sexual dysfunction, weight gain, obesity, excessive daytime sleepiness, increased work related and traffic related accidents and death. Side effects and complications of oral appliance therapy include: dental relationship changes, the development of discomfort of the lower jaw joint "TMJ", and or alteration in the position of the jaw joint. These changes may be temporary or permanent.

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Dental Side Effects and Complications of Oral Appliance Therapy: Published studies show that short-term side effects of oral appliance use may include excessive salivation, difficulty swallowing with appliance in place, sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth or dental restorations, and short term bite changes such as decreasing overbite and over jet (how the upper and lower teeth come together), tilting of the teeth, profile changes, as well as spacing and shifting of teeth. Most of these side effects are minor and resolve quickly on their own or with minor adjustments of the appliance. Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If so, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Alternative Treatments: By signing this consent form you acknowledge that you have been made aware of reasonable alternatives to oral appliance therapy for obstructive sleep apnea such as: behavioral modifications (weight loss, exercise, and positional therapy), positive airway pressure (CPAP), and several types of surgical procedures. It is your decision to have chosen oral appliance therapy to treat your sleep disordered breathing, and you are aware that it may not be completely effective for you. You have been shown several types of oral appliances and participated in the selection process. It is your responsibility to report any occurrence of side effects and to address any questions to Dr. Lamberg's office. You are aware that more than one type of treatment (combination therapy) may be necessary for the best sustainable results.

Wherefore: I give my consent for the treatment of OSA using a mandibular advancement device (MAD). I agree and consent to allow Dr. Lamberg and his staff to examine my mouth, teeth, jaws, gums, and associated structures. I give consent for the taking of x-rays, photos, impressions and any other procedures necessary for the treatment of OSA. I also give consent for a home sleep study, if necessary, for the purpose of evaluating and adjusting my appliance to the most effective position. I consent for the contents of my record to be shared with my physician and insurance company. I affirm that I have read this document and have been given adequate information regarding the treatment of my condition to give my informed consent. I understand the proposed treatment of my OSA using MAD therapy and I have been given the opportunity to ask questions. All of my questions have been answered and I am ready to proceed with treatment.

Signature:_____ Date_____

Patient Name:

Witness:_____Date_____

Print Name:_____

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Diplomate of the Academy of Clinical Sleep Disorders Disciplines

***Consent Form References**

Review of oral appliances for treatment of sleep-disordered breathing by Victor Hoffstein. Sleep Breath. 2007 March; 11(1): 1–22. Between 1982 and 2006, there were 89 distinct publications dealing with oral appliance therapy involving a total of 3,027 patients, which reported results of sleep studies performed with and without the appliance. These studies, which constitute a very heterogeneous group in terms of methodology and patient population, are reviewed and the results summarized. This review focused on the following outcomes: sleep apnea (i.e. reduction in the apnea/hypopnea index or respiratory disturbance index), ability of oral appliances to reduce snoring, effect of oral appliances on daytime function, comparison of oral appliances with other treatments (continuous positive airway pressure and surgery), side effects, dental changes (overbite and overjet), and long-term compliance. We found that the success rate, defined as the ability of the oral appliances to reduce apnea/hypopnea index to less than 10, is 54%. The response rate, defined as at least 50% reduction in the initial apnea/hypopnea index (although it still remained above 10), is 21%. When only the results of randomized, crossover, placebo-controlled studies are considered, the success and response rates are 50% and 14%, respectively. Snoring was reduced by 45%. In the studies comparing oral appliances to continuous positive airway pressure (CPAP) or to uvulopalatopharyngoplasty (UPPP), an appliance reduced initial AHI by 42%, CPAP reduced it by 75%, and UPPP by 30%. The majority of patients prefer using oral appliance more than CPAP. Use of oral appliances improves daytime function somewhat; the Epworth sleepiness score (ESS) dropped from 11.2 to 7.8 in 854 patients. A summary of the follow-up compliance data shows that at 30 months, 56–68% of patients continue to use oral appliance. Side effects are relatively minor but frequent. The most common ones are excessive salivation and teeth discomfort. Efficacy and side effects depend on the type of appliance, degree of protrusion, vertical opening, and other settings. We conclude that oral appliances, although not as effective as CPAP in reducing sleep apnea, snoring, and improving daytime function, have a definite role in the treatment of snoring and sleep apnea.

Initial_____ Date_____

Dental Health & Wellness of Long Island
ADVANCING HEALTH THROUGH DENTISTRY

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General Release of Liability and Assumption of Risk
for Obstructive Sleep Apnea

I, _____, understand that due to the nature of sleep medicine that failure to comply with the treatment can result in severe physical and social issues including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; hypertension; excessive sleepiness; and increased mortality.

As Dr. Steven Lamberg and North Shore Snoring and Sleep Apnea Dental Treatment Center cannot ensure success of any type of therapy and cannot guarantee that any patient will comply with the treatment for sleep apnea, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for any damage, physical or monetary, that I, or anyone else, might sustain as a result of my treatment for sleep apnea or any failure on my part to comply with treatment.

Therefore, I release Dr. Steven Lamberg and North Shore Snoring and Sleep Apnea Dental Treatment Center, and his staff, from any and all liability associated with my treatment and I personally assume all risks associated with my care, including, but not limited to: coronary artery disease; stroke; congestive heart failure; atrial fibrillation; diabetes; increased motor vehicle accidents; increased work place accidents; hypertension; excessive sleepiness; TMJ disease; periodontal disease and increased mortality.

I hereby agree to indemnify and hold harmless, Dr. Steven Lamberg, North Shore Snoring and Sleep Apnea Dental Treatment Center and his staff, and defend them from any and all claims or damages that might arise from my sleep apnea treatment.

Signature _____Date_____

Patient Name:

Witness _____Date _____

Please Print Name _____

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Statement of Delivery of Oral Appliance, Patient Use Instructions, Warnings, and Warrantee

Dear Patient,

I am happy to offer you an oral appliance today for your obstructive sleep apnea and look forward to helping you achieve the best possible results.

Oral Appliance Description:
E0486: ORAL DEVICE/APPLIANCE USED TO PREVENT AIRWAY COLLAPSIBILITY, CUSTOM FABRICATED, ADJUSTABLE, INCLUDES FITTING AND ADJUSTMENT.

Standard recommendations include manage your weight, stop smoking, do not drink in the evening, do not take sedatives in the evening, and try NOT to sleep on your back. Anything that inflames the airways or relaxes the muscles will render your airway more collapsible and therefore increase your sleep apnea condition.

I have received patient use instructions, cleaning, and warnings information, and been notified of warranty coverage of the oral appliance.

A minimum of four scheduled follow-up visits are necessary to evaluate the comfort of your appliance and make any necessary adjustments to maximize treatment success. Additional visits that you may need are encouraged and included. One take home sleep study is included during this time. Any additional take home sleep studies will be charged at $150 per study. Your appliance is warranted for 3 years against manufacturing defects. Repairs resulting from other causes may be charged our lab fee.

Appointments (minimum) that are included for a period up to 3 months from delivery.
Week 1_____@_____
Month 1_____ @_____
Month 2_____@ _____
Month 3_____@ _____

Periodic follow up visits will be scheduled at 6 Months, 12 Months, 24 Months, and 36 Months from the delivery date. These visits are charged at a fee of $80 per visit and is due at the time of the visit.

Month 6 _____@_____
Month 12 _____ @_____
Month 24_____@ _____
Month 36_____@ _____

Patient Signature_____Date_____

Medicare Proof of Oral Appliance Delivery Documentation

Beneficiary's name_____

Beneficiary's signature_____ Date _____

Delivery Address: 140 Main Street, Northport NY, 11768

Date of Delivery (must match signature date)_____

Name of Appliance_____

Name of Lab_____

Table of Contents

1. Purpose of the Lamberg Sleep Well Device:

The purpose of the Lamberg Sleep Well Device is to reduce or alleviate night time snoring and mild and moderate obstructive sleep apnea.

2. Description of the LSW Device:

Description of the Device: The Lamberg Sleep Well Device is a two part device that is worn in the mouth and is used for treating Snoring and Sleep Apnea. It consists of two distinct components, or plates, that engage the teeth of each of the dental arches separately. The upper dental plate and the lower dental plate are in contact only in the front area of the mouth by means of a patented coupling system comprised of a protrusive element on the upper dental plate and its complimentary mate on the lower dental plate. This interface serves to reposition the lower jaw, and therefore the tongue, forward. It is this forward repositioning of the tongue which acts to increase the patients' airway size, thus enhancing breathing while sleeping. Each device is custom made for the patient by prescription only, and is adjustable at the time of delivery and anytime thereafter.

3. Contraindications, Risks, Warnings, Cautions:

A. Contraindications The Device is Contraindicated in the following instances:

Central Sleep Apnea
Severe Respiratory disorders
Loose Teeth or advanced periodontal disease
Under 18 years of age
Edentulous or insufficient number of teeth to retain the device
Inadequate mandibular range of motion
Myofacial Dysfunction
Anthropathy of the TMJ
If the patient is undergoing any type of orthodontic treatment
If the patient is undergoing dental work that requires temporary crowns
Important Note: If the appliance is broken, do not wear it.

B. Risks Use of the device may cause:

Tooth movement or changes in the dental occlusion or bite
Gingival irritation or dental soreness
Pain or soreness of the TMJ or facial muscles
Obstruction of oral breathing
Excessive salivation
Loosening and or dislodgment of dental fillings or crowns.
A small percentage of patients actually increase their number of apneic and hypopneic events when using an oral appliance.

Important Note: Should you experience any of these adverse events, discontinue use of the device and call your dentist.

C. General Warnings

Performance may be adversely affected by: weight gain, obesity, alcohol consumption, sedative use, allergies, smoking, any cold or sickness that compromises nasal breathing, very high altitudes, increased age, and hormonal changes in women such as menapause. **DO NOT** modify the device and **DO NOT** share the device. If the appliance is broken, **DO NOT** wear it.

D. Cautions

The appliance should **NOT** be used as bleaching trays. Do **NOT** run or exercise with the appliance in your mouth.

4. Use Instructions

A. What to expect:

At Visit when you first receive your appliance: Initially, when the appliance is placed in your mouth you will, most likely, find it cumbersome.

First Night: There will be an increase in salivary flow for the first few weeks of use which will slowly subside. Some patients experience minor gagging or awkwardness swallowing, but these sensations are not permanent. After wearing the appliance all night it is common to have some minor tooth or muscle discomfort. Your bite may feel different for a short period in the morning. Some patients cannot touch their teeth together normally for up to 45 minutes. If this is a problem, lean on your hand for about 15 minutes each morning, as if you were the statue of "The Thinker" by Rodin. Most patients experience little if any discomfort after a few weeks of adapting to their intra-oral sleep apnea device. If there is continued discomfort, discontinue use and see your dentist.

Long Term:
Contacts between teeth may be less tight. Most patients experience little if any discomfort after a few weeks of adapting to their intra-oral sleep apnea device. If there is continued discomfort discontinue use and see your dentist.

B. Wearing the Appliance:

1. Prior to Inserting the appliance:
   Brush and floss your teeth.

2. Insertion:

Insert the appliance into your mouth when going to sleep.

Place the upper dental plate in your mouth onto the upper arch of teeth first and press up with your thumbs to make sure it is fully seated and secure and it does not rock. Then place the lower dental plate in your mouth on your lower teeth and press down until it is securely seated.

3. While it's in your mouth:

DO NOT pop the appliance in and out of your mouth with your tongue.

4. Removal:

Remove the lower dental plate first and then remove the upper dental plate. When removing the upper dental plate, pull down slowly on the metal loops by your upper molars.

5. If a tooth feels sore, or your experience muscle soreness, or joint soreness, bring the appliance into your dentist for an adjustment.

6. If the appliance is broken, **DO NOT** wear it. Bring it to your dentist.

C. Cleaning:

Clean your appliance each morning after every use with a denture toothbrush or a regular toothbrush using either toothpaste or a denture cleaning paste such as Dentu-Creme or Fresh n Brite which you will find in your supermarket. Use cold water only when cleaning your appliance. Take care to brush all surfaces, inside and out. If a white film starts to form on the appliance, or you detect odors from it, or approximately once a week, we recommend that you soak the appliance in a denture cleaning solution. There are many commercially available denture cleaning solution products available such as Polident or Efferdent which you will find at your supermarket, or ORAL SAFE appliance cleaner which is available from Great Lakes Laboratories at 1-800-828-7626. Follow the manufacturers instructions when using these products. After cleaning, rinse appliance under cool water. Completely air dry before storing.

CAUTION:

DO NOT soak the appliance in mouthwash or alcohol, or bleach as these may weaken your appliance.

DO NOT place in hot or boiling water or expose to excessive heat as this could distort the appliance.

D. Storing:

Always completely dry the appliance before storing. Place in a dry plastic case whenever it is not in your mouth. Keep your appliance so that family pets cannot reach it.

E. Maintenance / Observation Visits With Your Dentist

1. Follow-up visits are necessary at the following intervals:

Week 1- for comfort check and to make any necessary adjustments for the fit of the appliance and the jaw position.

Month 1, 2, and 3 - for evaluation of your teeth and the appliance and to make any necessary adjustments in jaw position.

6 months - to check on your progress with the appliance.

Yearly thereafter - See your dentists once a year to inspect your teeth and the appliance. This will help minimize any side effects in your mouth and allow the dentist to make any necessary repairs to the appliance.

Important Note: It is essential to be undergo some type of objective sleep testing, either with a home sleep testing device such as the Watch PAT by Itamar Medical OR an overnight attended PSG, to evaluate the efficacy of the appliance.

Important Note: The need to adhere to this maintenance care regimen cannot be overstated. The follow-up visits listed above are the minimum amount of visits necessary to assure the best possible experience for you. You should call your dentist for additional visits whenever you feel they may be necessary. To insure the best possible outcome with the appliance it is essential to have a proper fit and to have your mouth evaluated with follow-up visits on a regular basis.

2. The appliance should last for 2-3 years depending on how well you care for it.

3. Inspect your appliance regularly. If you notice any chipping or cracking in the appliance, or the clasps are bent, or it seems to fit differently, see your dentist as soon as possible to repair or replace the appliance as these changes could effect its proper functioning and or safety.

F. User Assistance Contact Information:

Dr. Steven Lamberg, 631-678-1604, your dentist, or a certified laboratory.

5. Warranty

The Lamberg Sleep Well Device is custom made for you from materials to ensure comfort and durability. Your device is warranted by the certified laboratory used by your dentist. This is a manufacturers warranty and NOT a claim for stopping snoring or improving your obstructive sleep apnea. If your Lamberg Sleep Well Device is broken, it is very important that you cease using the device and contact your dentist to have it repaired immediately.

6. Additional Information

A. Clinical Studies

1. Summary of data for the LSW Device Note.
   See appendix for data tables

2. Summary of literature on oral appliances to guide expectations.

Review of oral appliances for treatment of sleep-disordered breathing by Victor Hoffstein. Sleep Breath. 2007 March; 11(1): 1–22.

Between 1982 and 2006, there were 89 distinct publications dealing with oral appliance therapy involving a total of 3,027 patients, which reported results of sleep studies performed with and without the appliance. These studies, which constitute a very heterogeneous group in terms of methodology and patient population, are reviewed and the results summarized. This review focused on the following outcomes: sleep apnea (i.e. reduction in the apnea/hypopnea index or respiratory disturbance index), ability of oral appliances to reduce snoring, effect of oral appliances on daytime function, comparison of oral appliances with other treatments (continuous positive airway pressure and surgery), side effects, dental changes (overbite and overjet), and long-term compliance. We found that the success rate, defined as the ability of the oral

appliances to reduce apnea/hypopnea index to less than 10, is 54%. The response rate, defined as at least 50% reduction in the initial apnea/hypopnea index (although it still remained above 10), is 21%. When only the results of randomized, crossover, placebo-controlled studies are considered, the success and response rates are 50% and 14%, respectively. Snoring was reduced by 45%. In the studies comparing oral appliances to continuous positive airway pressure (CPAP) or to uvulopalatopharyngoplasty (UPPP), an appliance reduced initial AHI by 42%, CPAP reduced it by 75%, and UPPP by 30%. The majority of patients prefer using oral appliance than CPAP. Use of oral appliances improves daytime function somewhat; the Epworth sleepiness score (ESS) dropped from 11.2 to 7.8 in 854 patients. A summary of the follow-up compliance data shows that at 30 months, 56–68% of patients continue to use oral appliance. Side effects are relatively minor but frequent. The most common ones are excessive salivation and teeth discomfort. Efficacy and side effects depend on the type of appliance, degree of protrusion, vertical opening, and other settings. We conclude that oral appliances, although not as effective as CPAP in reducing sleep apnea, snoring, and improving daytime function, have a definite role in the treatment of snoring and sleep apnea.

Sleep Hygiene Recommendations for the LSW

Body Position:

Supine position (on your back) is the worst position for sleeping because gravity causes the tongue to fall back and down which blocks the airway. Side sleeping or prone (on your stomach) causes less restriction of the airway.

Enhancing your sleep environment:

1. **Sleep in complete darkness**. Light in the room can disrupt your internal clock by impairing production of melatonin. Even the tiniest light from your clock radio could pass through your eyelid, stimulate nerves on your retina, and interfere with your sleep. Cover up your clock radio and small lights on your cable box. Close your bedroom door, and get rid of night-lights. Refrain from turning on any light at all during the night, even when getting up to go to the bathroom. Cover your windows. Modern day electrical lighting has significantly betrayed your inner clock or "Circadian Rhythms".

2. **Keep the temperature in your bedroom under 70 degrees F**. Many people keep their homes, and particularly their upstairs bedrooms, too warm. Studies show that the optimal room temperature for sleep is quite cool, between 60 to 68 degrees. Keeping your room cooler or hotter can lead to restless sleep.

   When you sleep, your body's internal temperature drops to its lowest level, generally about four hours after you fall asleep. A cooler bedroom may be most conducive to sleep, since it mimics your body's natural temperature drop.

3. **Check your bedroom for electro-magnetic fields (EMFs)**. These can disrupt the pineal gland and the production of melatonin and serotonin, and may have other negative effects as well. To do this, you need a Gauss meter. (online)

4. **Move alarm clocks and other electrical devices away from your bed**. Keep these devices as far away from your bed as possible, preferably at least 3 feet. *Remove the clock from view.*

5. **Reserve your bed for sleeping**. If you are used to watching TV or doing work in bed, you may find it harder to relax and drift off to sleep, so avoid doing these activities in bed.

6. **Consider separate bedrooms**. Recent studies suggest, for many people, sharing a bed with a partner (or pets) can significantly impair sleep, especially if the partner is a restless sleeper or snores.

Sleep Hygiene Recommendations for the LSW

Preparing for Bed:

1. **Get to bed as early as possible**. Your body (particularly your adrenal system) does a majority of its recharging between the hours of 11 p.m. and 1 a.m. In addition, your gallbladder dumps toxins during this same period. If you are awake, the toxins back up into your liver, which can further disrupt your health.

   Prior to the widespread use of electricity, people would go to bed shortly after sundown, as most animals do, and which nature intended for humans as well.

2. **Don't change your bedtime**. You should go to bed and wake up at the same times each day, even on the weekends. This will help your body to get into a sleep rhythm and make it easier to fall asleep and get up in the morning.

3. **Establish a bedtime routine.** This could include meditation, deep breathing, aromatherapy or indulging in a massage from your partner. Find something that makes you feel relaxed, then repeat it each night.

4. **Don't drink any fluids within 2 hours of going to bed**. This will reduce the likelihood of needing to get up and go to the bathroom, or at least minimize the frequency. **Go to the bathroom right before bed.** This will reduce the chances that you'll wake up to go in the middle of the night.

5. **Eat a high-protein snack several hours before bed**. This can provide the L-tryptophan needed for your melatonin and serotonin production.

6. **Also eat a small piece of fruit**. This can help the tryptophan cross your blood-brain barrier.

7. **Avoid before-bed snacks, particularly grains and sugars**. These will raise your blood sugar and delay sleep. Later, when blood sugar drops too low (hypoglycemia), you may wake up and be unable to fall back asleep.

8. **Take a hot bath, shower or sauna before bed**. When your body temperature is raised in the late evening, it will fall at bedtime, facilitating slumber. The temperature drop from getting out of the bath signals your body it’s time for bed.

9. **Wear an eye mask to block out light.** It is very important to sleep in as close to complete darkness as possible. It's not always easy to block out every stream of light using curtains, blinds or drapes. In these cases, an eye mask can be helpful.

10. **Put your work away at least one hour before bed (preferably two hours or more).** This will give your mind a chance to unwind so you can go to sleep feeling calm, not hyped up or anxious about tomorrow's deadlines.

Sleep Hygiene Recommendations for the LSW

11. If you have difficulty breathing through your nose try to clear up your nasal passages with a steamy shower or a Nettie Pot which will help your breathing.

12. **No TV or computer right before bed**. It's too stimulating to the brain, preventing you from falling asleep quickly and any ambient light disrupts the production of Melatonin in your pineal gland.

13. **Listen to relaxation CDs**. Some people find the sound of white noise or nature sounds, such as the ocean or forest, to be soothing for sleep. Eliminate any sounds that interfere with falling asleep.

14. **Read something spiritual or uplifting**. This may help you relax. Don't read anything stimulating, such as a mystery or suspense novel.

Lifestyle Suggestions That Enhance Sleep:

1. **Reduce or avoid as many drugs as possible.** Many drugs, both prescription and over-the-counter, may adversely affect sleep.

2. **Avoid caffeine.** An afternoon cup of coffee or tea will keep some people from falling asleep at night. Many medications contain caffeine (for example, diet pills).

3. **Avoid alcohol.** (6 hours before bed) Alcohol will make you drowsy, but the effect is short and you may wake up several hours later, unable to fall back asleep.

4. **Avoid smoking.** Too many health reasons to list.

5. **Make certain you are exercising regularly.** Exercising for at least 30 minutes per day can improve your sleep. However, don't exercise too close to bedtime or it may keep you awake. I recommend yoga to help quiet the mind.

6. **Lose excess weight.** Being overweight can reduce your airway size and increase your risk of sleep apnea, which can seriously impair your sleep. I am happy to recommend a dietician to help you tweak your eating habits.

7. **If you are menopausal or perimenopausal, get checked out by a good natural medicine physician**. Hormonal changes may cause sleep problems.

8. **Consider B12 supplementation.** Vegetarians and people over 50 may be deficient in B12 and may benefit from this supplement which plays a vital role in the production of Melatonin. Additionally this supplement will give you an energy boost, improve your mood and memory, and help in metabolism of fats and carbohydrates.

Sleep Hygiene Recommendations for the LSW

If All Else Fails:

1. **One behavior to alleviate insomnia is Emotional Freedom Technique (EFT).** Most people can learn the basics of this gentle tapping technique in a few minutes. EFT can help balance your body's bioenergy system.

2. **Supplemental Melatonin**. It is best to increase levels naturally with exposure to bright sunlight in the daytime and absolute complete darkness at night. Melatonin is a completely natural substance, made by your body, and has many health benefits in addition to sleep. You may want to consider a melatonin supplement.

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Affidavit of Sleep Apnea Therapy

- ❑ I have mild or moderate sleep apnea and per the American Academy of Sleep Medicine, CMS Guidelines and insurance policy, I would like to use oral appliance therapy as first line treatment.
- ❑ I have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):
  - ❑ Mask Leaks
  - ❑ An Inability to get the Mask to Fit Properly
  - ❑ Discomfort Caused by the Straps and Headgear
  - ❑ Disturbed or Interrupted Sleep Caused by the Presence of the Device
  - ❑ Noise From the Device Disturbing Sleep or Bed/Partner's Sleep
  - ❑ CPAP Restricted Movements During Sleep
  - ❑ CPAP Does Not Seem To Be Effective
  - ❑ Pressure On The Upper Lip Causes Tooth Related Problems
  - ❑ Latex Allergy
  - ❑ Claustrophobic Associations
  - ❑ An Unconscious Need to Remove the CPAP Apparatus at Night
  - ❑ Other (please specify): _____

Because of my intolerance/inability to use the CPAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Signed: _____

Date: _____

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	___
Watching TV	___
Sitting, inactive in a public place (e.g. a theatre or a meeting)	___
As a passenger in a car for an hour without a break	___
Lying down to rest in the afternoon when circumstances permit	___
Sitting and talking to someone	___
Sitting quietly after a lunch without alcohol	___
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

10/6/21

To Whom It May Concern:

Anna Fabela has been evaluated for TMJ and periodontal disease and there is no evidence of either. She also has adequate detention to support the oral appliance.

Thank you,

Dr. Steven Lamberg DDS

Dental Health & Wellness of Long Island

ADVANCING HEALTH THROUGH DENTISTRY

Airway/Sleep Evaluation
- ❑Sleep Disordered Breathing
- ❑UARS
- ❑CPAP Intolerant
- ❑RX HSAT
- ❑Eval for oral appliance E0486
- ❑Eval for Non-Anatomic Contributions

Records Forwarded
- ❑PSG/HSAT
- ❑Letter of Medical Necessity
- ❑RX for OSA with DX Code G47.33
- ❑Recent Chart Notes

Dental Evaluation
- ❑Oral Health Evaluation
- ❑Total Mouth Disinfection (recommended for all CVD patients)
- ❑Restorative Evaluation Tooth # ____
- ❑Cosmetic, Digital Smile Design

Notes:_____

_____

_____

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