# Disclaimer

AADSM Dental Sleep Medicine (DSM) Facility Accreditation does not influence in any way a state's dental scope of practice. The facility accreditation program helps set standards for the practice of DSM, which includes oral appliance therapy and upper-airway surgery to treat sleep-related breathing disorders such as snoring and obstructive sleep apnea, and to assure professional dental and medical colleagues, patients, and the public of an acceptable level of education, training, and experience by dental directors and staff.

Accreditation does not represent a new specialty of dentistry or medicine, nor does it grant or imply any legal qualification, privilege or license to practice. Accreditation does recognize DSM facilities that have passed a thorough application process and met the requirements set forth by the AADSM.

# Form I.
# General Information

**DSM Facility Information**

| Refer to Standard A-1 for details | | |
|---|---|---|
| Name of DSM Facility: | | |
| Location Address: | | |
| | | |
| City: | State: | Zip: |
| Phone Number: | | |
| Fax Number: | | |
| Web Address: | | |
| Mailing Address: | | ☐ **Same As Above** |
| City: | State: | Zip: |

| | |
|---|---|
| Primary Contact: | |
| Title: | |
| Phone Number: | |
| E-mail: | |

| Refer to Standard D-2 for details | Hours of Operation |
|---|---|
| Monday: | Thursday: |
| Tuesday: | Friday: |
| Wednesday: | Saturday: |
| Sunday: | |

**Only complete this section of the application if the facility has a satellite facility.*

| Refer to Standard D-4 for details |
|---|
| Please indicate the average number of dental sleep medicine patient care hours that have been dedicated to the ***primary facility*** per week over the most recent quarter.<br><br>_____ dental sleep medicine patient care hours |

**Satellite Facility 1** ***(if applicable)***

| Refer to Standards B-1b & D-1 for details | | |
|---|---|---|
| Name of DSM Facility: | | |
| Location Address: | | |
| | | |
| City: | State: | Zip: |
| Phone Number: | | |
| Fax Number: | | |
| Web Address: | | |
| Mailing Address: | | ☐ **Same As Above** |
| City: | State: | Zip: |

| | |
|---|---|
| Primary Contact: | |
| Title: | |
| Phone Number: | |
| E-mail: | |

| Refer to Standard D-2 for details | Hours of Operation |
|---|---|
| Monday: | Thursday: |
| Tuesday: | Friday: |
| Wednesday: | Saturday: |
| Sunday: | |

| Refer to Standard D-4 for details |
|---|
| Please indicate the average number of dental sleep medicine patient care hours that have been dedicated to this *satellite facility* per week over the most recent quarter.<br><br>_____ dental sleep medicine patient care hours |

**Satellite Facility 2** ***(if applicable)***

| Refer to Standards B-1b & D-1 for details | | |
|---|---|---|
| Name of DSM Facility: | | |
| Location Address: | | |
| | | |
| City: | State: | Zip: |
| Phone Number: | | |
| Fax Number: | | |
| Web Address: | | |
| Mailing Address: | | ☐ **Same As Above** |
| City: | State: | Zip: |

| | |
|---|---|
| Primary Contact: | |
| Title: | |
| Phone Number: | |
| E-mail: | |

| Refer to Standard D-2 for details | Hours of Operation |
|---|---|
| Monday: | Thursday: |
| Tuesday: | Friday: |
| Wednesday: | Saturday: |
| Sunday: | |

| Refer to Standard D-4 for details |
|---|
| Indicate the average number of dental sleep medicine patient care hours that have been dedicated to this ***satellite facility*** per week over the most recent quarter.<br><br>_____ dental sleep medicine patient care hours |

# Form II.
# Staff List

## Refer to Standard B-5 for details

List only the staff members involved in dental sleep medicine below. If a staff member has two or more roles in dental sleep medicine, list their name in each applicable section below and designate how many hours per week they spend in each role.

| Name | Credentials | Position | Date of Hire (Month/Year) | Avg. Hours Worked/Week |
|---|---|---|---|---|
| | | Dental Director | | |
| Clinical Staff<br>*(including other dentists on staff involved in dental sleep medicine)* | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Administrative Staff | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Coding/Billing Staff | | | | |
| | | | | |
| | | | | |
| | | | | |

# Form II.
# Staff List

**Satellite Facility 1** ***(if applicable)***

Refer to Standard B-5 for details

| Name | Credentials | Position | Date of Hire (Month/Year) | Avg. Hours Worked/Week |
|---|---|---|---|---|
| Dental Director | | | | |
| | | Dental Director | | |
| Clinical Staff<br>*(including other dentists on staff involved in dental sleep medicine)* | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Administrative Staff | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Coding/Billing Staff | | | | |
| | | | | |
| | | | | |
| | | | | |

# Form II.
# Staff List

**Satellite Facility 2** ***(if applicable)***

Refer to Standard B-5 for details

| Name | Credentials | Position | Date of Hire (Month/Year) | Avg. Hours Worked/Week |
|---|---|---|---|---|
| Dental Director | | | | |
| | | Dental Director | | |
| Clinical Staff<br>*(including other dentists on staff involved in dental sleep medicine)* | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Administrative Staff | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Coding/Billing Staff | | | | |
| | | | | |
| | | | | |
| | | | | |

# Form III.
# Legal Ownership Disclosure
(if different than listed on Form I.)

## Refer to Standard M-1 for details

| Legal Owner 1. | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone Number: | | |
| Ownership Relationship: | | |

| Legal Owner 2. | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone Number: | | |
| Ownership Relationship: | | |

| Legal Owner 3. | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone Number: | | |
| Ownership Relationship: | | |

If the applicant DSM facility has more than three legal owners, please make additional copies of this form.

| I attest that this list is true and complete to the best of my knowledge. |
|---|
| Dental Director Signature: |
| Date: |

# Documentation I.
# Facility License

## Refer to Standard A-2 for details

Check the one box below that accurately describes the DSM facility and provide the requested documentation.

☐ Applicable law and regulation requires the DSM facility and satellite facilities (if applicable) to maintain a valid license, certificate of occupancy, and/or permit.

**Documentation to provide:**

- Copy of a valid license, certificate of occupancy, and/or permit to provide health care services

OR

☐ Applicable law and regulation **DOES NOT** require the DSM facility and satellite facilities (if applicable) to maintain a valid license, certificate of occupancy, and/or permit to provide health care services.

**Documentation to provide:**

- Attestation I. *(below)*

# Attestation I.
# Facility License

*If the DSM facility and satellite facilities (if applicable)* ***is not required to maintain a valid license, certificate of occupancy, and/or permit****, he/she must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that applicable law and regulation does not require the DSM facility and satellite facilities (if applicable) to have a healthcare license, certificate of occupancy or business permit, or DME license or permit.

Dental Director Signature _____ Date _____

# Documentation II.
# Dental Director Qualifications

## Refer to Standards B-1, B-2 & B-4 for details

Check the box that accurately describes the dental director's qualifications and provide the requested documentation.

☐ Diplomate of the American Board of Dental Sleep Medicine (ABDSM)

**Documentation to provide:**

- Copy of ABDSM certificate
- Copies of CE letters and/or certificates with supporting course agendas *(25 hours of recognized continuing education in dental sleep medicine (i.e. ADA CERP recognized or AGD PACE approved) provided by a non-profit organization or university in the past two years. Up to 10 of the 25 credits may be sleep medicine related AMA PRA Category 1 CME. Course agendas must demonstrate CE hours covered clinical dental sleep medicine or sleep medicine topics and not practice management or billing.)*
- Copy of dental director's license

OR

☐ NOT a Diplomate of the ABDSM

**Documentation to provide:**

- Copies of CE letters and/or certificates with supporting course agendas *(25 hours of recognized continuing education in dental sleep medicine (i.e. ADA CERP recognized or AGD PACE approved) provided by a non-profit organization or university in the past two years. Up to 10 of the 25 credits may be sleep medicine related AMA PRA Category 1 CME. Course agendas must demonstrate CE hours covered clinical dental sleep medicine or sleep medicine topics and not practice management or billing.)*
- Copy of dental director's license
- Attestation II. *(below)*

# Attestation II.
# Dental Director Qualifications

*If the dental director of the DSM facility is **not a Diplomate of the ABDSM**, he/she must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that I have delivered a minimum of twelve appliances within the previous 12 months.

Dental Director Signature _____ Date _____

# Documentation III.
# Clinical Auxiliary Staff Continuing Education

## Refer to Standard B-6 for details

All clinical staff as listed on Form II. must maintain 15 hours of ADA CERP or AGD PACE recognized credit in dental sleep medicine every three years. Facilities that are applying for accreditation for the first time are only required to provide documentation of 5 hours of ADA CERP or AGD PACE recognized credit in dental sleep medicine per clinical staff within the past 12 months of when the application is submitted.

Check the box that applies to the DSM facility's clinical auxiliary staff's continuing education and provide the requested documentation.

☐ Continuing education was earned **OUTSIDE** of the DSM facility

**Documentation to provide:**

- Copies of CE letters and/or certificates from CE providers

AND/OR

☐ Continuing education was earned **WITHIN** the DSM facility

**Documentation to provide:**

- Copy of the Auxiliary Staff CE Attendance Sheet *(located at aadsm.org/accreditationtips.aspx)*

# Documentation IV.
# Auxiliary Staff Continuing Education

## Refer to Standard B-9 for details

Check the box that applies to the DSM facility's staff who are responsible for administrative services and provide the requested documentation.

☐ All staff who oversee administrative responsibilities have been actively engaged in administrative responsibilities for dental sleep medicine services at this DSM facility for more than one year.

OR

☐ There is one or more staff member(s) who is responsible for administrative services that have been actively engaged in administrative services at this DSM facility for one year or less.

**Documentation to provide:**

- Copy of at least one of the following verifying a minimum of 2 hours of relative training for each administrative staff who have been actively engaged in administrative services at this DSM facility for one year or less:

  CE letter(s) from either an ADA CERP recognized or AGD PACE approved provider (for CE earned *outside* of the facility)

  OR

  Educational objectives, attendance sheets signed by the dental director and course outlines (for CE earned *within* the facility)

## Documentation V.
## Auxiliary Staff Additional Certification

### Refer to Standard B-7 for details

Provide the requested documentation.

**Documentation to provide:**

- Copies of valid CPR certificates for the dental director and each clinical auxiliary staff member listed on Form II. *(either through the American Heart Association or American Red Cross)*

## Documentation VI.
## Coding and Billing Personnel Training

### Refer to Standard B-8 for details

Check the box that applies to the DSM facility's staff who are responsible for coding and billing of services and provide the requested documentation.

☐ All staff who are responsible for coding and billing have been actively engaged in coding and billing for dental sleep medicine services at this DSM facility for more than one year.

OR

☐ There is one or more staff member(s) who is responsible for coding and billing that have been actively engaged in coding and billing at this DSM facility for one year or less.

**Documentation to provide:**

- Copy of at least one of the following verifying a minimum of 5 hours of training for each coding and billing staff who is actively engaged in coding and billing at this DSM facility for one year or less *(see Standards for Accreditation for suggested areas of training)*:
  - Training materials
  - Attendance sheets
  - Course outlines

OR

☐ A third party company is responsible for handling all coding and billing at this DSM facility.

## Documentation VII.
## DSM Facility Availability

### Refer to Standard D-2 for details

Check all boxes that apply to the DSM facility and provide the requested documentation if applicable.

☐ The DSM facility advertises.

**Documentation to provide:**

- Copies of any advertising materials displaying facility's address and phone number.

☐ The DSM facility distributes patient education materials.

**Documentation to provide:**

- Copies of any patient education materials displaying facility's address and phone number.

☐ The DSM facility **DOES NOT** advertise or distribute patient education materials.

## Documentation VIII.
## Quality Assurance Report

### Refer to Standard L-1 for details

Provide the requested documentation.

**Documentation to provide:**

- Copy of the most recent quarterly report of quality assurance

## Attestation IV.
## ADA Code of Ethics

### Refer to Standard A-3 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that the dental sleep medicine facility follows the *American Dental Association Principles of Ethics and Code of Professional Conduct* and that an updated copy of the *Association Principles of Ethics and Code of Professional Conduct* is easily accessible to DSM facility staff.

Dental Director Signature _____ Date _____

## Attestation V.
## Dental Sleep Medicine Activity

### Refer to Standard A-4 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that the dental director has provided dental sleep medicine (DSM) services within this facility for a minimum of one year. DSM services include: 1) a minimum of 12 appliance insertions during this period, 2) documentation of post-delivery follow-up and short-term follow-up for each, and 3) documentation of long-term follow-up for no fewer than 5 of these cases.

Dental Director Signature _____ Date _____

## Attestation VI.
## Dental Director Responsibilities

### Refer to Standard B-3 for details

*The dental director of the DSM facility must complete and submit this checklist and attestation with the application for DSM facility accreditation.*

I _____, hereby attest that I am present in the dental sleep medicine facility on a regular basis and not less than 40 hours each month. I also attest that, as the dental director, I:

- Am responsible for the direct or indirect and ongoing oversight of patient evaluation, treatment, and follow-up care
- Am responsible for proper handling, storage, maintenance, and ongoing assessment of oral appliances
- Am responsible for the qualifications of all dentists and auxiliary personnel
- Provide direct and ongoing oversight of the evaluation and testing protocols, as permitted under local laws and regulations
- Review, report, and modify as necessary the facility's quality assurance program on a quarterly basis

Dental Director Signature _____ Date _____

## Attestation VII.
## Consultation Rooms – Physical Characteristics

### Refer to Standard D-3 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that all treatment rooms are hygienic and suitably equipped to provide good light and oral access for a thorough intraoral and extraoral evaluation. Patient consultations at the DSM facility are provided in a private environment.

Dental Director Signature _____ Date _____

## Attestation VIII.
## Satellite Clinical Locations

### Refer to Standard D-4 for details

*If the director of the dental sleep medicine facility is also the director of satellite clinical facilities (maximum of two), the dental director must complete and submit this attestation with the application for DSM facility accreditation. If there are no satellites facilities operating under the same dental director it is not necessary to sign this attestation.*

I _____, hereby attest that the DSM satellite clinical facility(s) listed on Form II. cumulatively provide no more than 20% of the total monthly available DSM patient hours and that the DSM satellite clinical facility(s) operates under the same federal tax ID number as the main DSM facility. I also attest that I am physically present within each DSM satellite clinical facility during dental sleep medicine patient care hours for a minimum of 25% of each satellite facility's available patient care hours.

Dental Director Signature _____ Date _____

## Attestation IX.
## Oral Appliance Therapy

### Refer to Standard C-4 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that all patients receiving an oral appliance for treatment of sleep-related breathing disorders receive the following:

- Review of sleep-related breathing disorders and potential consequences if left untreated
- Review of treatment alternatives for sleep-related breathing disorders
- Benefit of treatment recommendations
- Potential risks and complications related to treatment recommendations
- Oral appliance care and use instructions
- Follow-up care per the AASM Practice Parameters and AADSM Practice Protocols

Documentation of the review of this information is maintained in the patient record.

Dental Director Signature _____ Date _____

## Attestation X.
## Appropriate Oral Appliances

### Refer to Standards E-1 & E-2 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that all patients receiving an oral appliance for treatment of sleep-related breathing disorders receive 510K FDA cleared, quality oral appliances as described in standard E-1. I attest that the DSM facility has the manufacturer features, warranties and instructions available for the oral appliance(s) that it provides, including documentation of FDA clearance.

Dental Director Signature _____ Date _____

## Attestation XI.
## Oversight

### Refer to Standard H-1 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that a face-to-face meeting between the patient and a qualified dentist member of the DSM facility is conducted prior to the fitting of an oral appliance.

Dental Director Signature _____ Date _____

## Attestation XII.
## Patient Rights

### Refer to Standard H-2 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that all patient's rights are protected during all interactions with the DSM facility. I attest that all patients of the DSM facility are given the right to considerate and respectful service without regard to race, creed, national origin, sex, age, disability, diagnosis, or religious affiliation. Additionally, I attest that DSM facility staff provides patients and prospective patients with sufficient information to base a decision regarding facility selection.

Dental Director Signature _____ Date _____

## Attestation XIII.
## Plan of Care/Informed Consent

### Refer to Standard H-3 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that the DSM facility provides all patients with a written plan of care following the initial evaluation and prior to fabricating an oral appliance for treatment of sleep-related breathing disorders. I attest that all patients give informed consent before initiating oral appliance therapy.

Dental Director Signature _____ Date _____

## Attestation XIV.
## Receipt of Oral Appliances

### Refer to Standard H-4 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that, as applicable, the DSM facility:

- Provides information to the patient regarding expected delivery time for receipt of the prescribed oral appliance.
- Documents that the appliance was personally checked by the treating dentist for structural integrity.
- Provides a written warranty for the appliance that delineates what support is included in the appliance fee and what services are likely to be needed at additional cost.
- Verifies and documents in the patient's chart the patient's receipt of the appliance.
- Provides daytime and after-hours contact information to each patient at the time of delivery of the prescribed appliance.

Dental Director Signature _____ Date _____

## Attestation XV.
## Verification of Training

### Refer to Standard H-5 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that the DSM facility:

- Provides, or coordinates the provision of, appropriate information related to the set-up, features, routine use, troubleshooting and maintenance of the appliance provided to the patient.
- Supplies to the patient and/or caregiver(s) clear, written or pictorial, oral or electronic instructions related to the use, maintenance, infection control practices for, and potential hazards of, the oral appliance as appropriate.

Dental Director Signature _____ Date _____

## Attestation XVI.
## Emergency Equipment

### Refer to Standard I-2 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that all appropriate emergency equipment to address all possible emergencies outlined in the emergency plan are accessible to the DSM facility staff.

Dental Director Signature _____ Date _____

## Attestation XVII.
## Follow-up Care

### Refer to Standard J-1 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that the DSM facility provides appropriate follow-up care services to the patient and/or caregiver(s) consistent with the type(s) of oral appliance and/or services(s) provided.

Dental Director Signature _____ Date _____

## Attestation XVIII.
## Post Delivery Follow-up

### Refer to Standard J-2 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that a member of the DSM facility staff places phone calls, sends e-mails, or otherwise attempts to directly contact patients 1-3 days after delivering a new oral appliance. I attest that the patients are given the opportunity to review instructions, express concerns, and provide feedback and that this contact is documented in the patient chart.

Dental Director Signature _____ Date _____

## Attestation XIX.
## Short-term Follow-up

### Refer to Standard J-3 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that the DSM facility offers face-to-face follow-up to patients who are prescribed oral appliance therapy to ensure adherence, address patient concerns, assess appliance fit, and check for complications within four weeks of initiating therapy. I attest that additional follow-up visits are provided every 1-12 weeks until the oral appliance home titration phase is successfully completed, the oral appliance has reached its maximum limit of mandibular advancement, or the patient has reached his/her tolerable limit of mandibular advancement. In addition, I attest that documentation of short-term follow-up is documented in the patient chart.

Dental Director Signature _____ Date _____

## Attestation XX.
## Long-term Adherence with OAT

### Refer to Standard J-4 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that the DSM facility encourages long-term follow-up to patients who are prescribed oral appliance therapy. I attest that the facility maintains a follow-up protocol which includes a face-to-face evaluation at six months after successful titration and at least annually thereafter. Additionally, I attest that long-term follow-up is documented in the patient record and that progress notes, follow-up reports and other pertinent information is shared with the patient's physician and appropriate healthcare providers on a regular basis. Lastly, I attest that the DSM facility documents notification of the treating physician whenever staff or myself become aware that any patient has discontinued oral appliance therapy for a sleep-related breathing disorder.

Dental Director Signature _____ Date _____

## Attestation XXI.
## Patient Records Audit

### Refer to Standard K-1 for details

*The dental director of the DSM facility must complete and submit this attestation with the application for DSM facility accreditation.*

I _____, hereby attest that a minimum of five patient records are self-audited at least annually by the DSM facility and that the audit demonstrates the following:

- Accurately coded bills for oral appliances documented in the patient chart.
- Reasonable and medically necessary oral appliances have been provided to the patient.

I also attest that the DSM facility will maintain documentation of annual audits for the duration of the accreditation period.

Dental Director Signature _____ Date _____

# Checklist
# Policy and Procedures Manual

Submit your complete Policy and Procedures Manual addressing all requirements outlined in the following standards:

- Standard C-1
- Standard F-1
- Standard F-2
- Standard F-3
- Standard F-4
- Standard G-1
- Standard G-2
- Standard G-3
- Standard H-6
- Standard I-1
- Standard J-4
- Standard K-2
- Standard L-1

The AADSM has a sample Policy and Procedures Manual for the Accreditation of Dental Sleep Medicine Facilities which contains template policies and procedures as well as sample forms and report templates to guide the applicant in the development of their facility-specific manual. The template manual can be purchased through the AADSM's Online Store.