Reimbursement for Sleep Testing and Treatment

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Conflict of Interest Disclosures

<table>
<thead>
<tr>
<th>Type of Potential Conflict</th>
<th>Details of Potential Conflict</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>Jazz (Xyrem)</td>
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<tr>
<td>Speakers’ Bureaus</td>
<td>Jazz (Xyrem)</td>
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<tr>
<td>Other</td>
<td>Affiliated with SleepMed Inc</td>
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<tr>
<td></td>
<td>SleepMed owns WaterMark, a manufacturer of a home sleep testing device and service.</td>
</tr>
</tbody>
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Interest Disclosures

- American Academy of Neurology: RUC Member
- AAN: Medical Econ & Management Committee Member
- Founding Member: Maryland Sleep Consortium
- Founding Member: Virginia Academy of Sleep Medicine
- Former Member: AASM Health Policy Committee

Sleep Medicine: Strategies for Change

Integrated Sleep Center: the Pack Proposal

- Focus on outcomes; diagnose & treat all sleep disorders
- Capacities:
  - *In-lab PSG and OOCT*
  - Physician & non-physician providers
  - Provide PAP, surgery, CBT, oral appliances
  - Embed sleep practice with general medicine
  - Define & capture outcomes data: sleep & medical
  - (Accreditation: Center, OOCT, DME)
- Pack, J Clin Sleep Med Dec 2011

Sleep Testing

- Home sleep tests, sleep studies or PSGs
  - Technical language
- Attended or unattended
  - “Attended facility-based polysomnogram means . . . . a technologist supervises the recording during sleep time and has the ability to intervene if needed.” Medicare PFS Oct 2008
- Record 6 hrs or more; except MSLT/actigraphy
- CPT Assistant Nov 2011:
  - Sleep Testing Guidelines Revisions; def tech terms
### Sleep Testing Codes 2013

- **95805**: Multiple sleep latency testing (MSLT), recording, analysis and interpretation of physiological measurements of sleep during multiple nap opportunities.
- **95806**: Polysomnography, younger than 6 years; sleep staging with 4 or more additional parameters of sleep, attended by a technologist.
- **95782**: Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist.
- **95800**: Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time.
- **95801**: Sleep study, unattended, simultaneous recording minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone) [3 no sleep].
- **95806**: Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist [4 including effort+flow].

### Home Sleep Testing – New Codes 2011

- **95800**: Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time [3+sleep time].
- **95801**: Sleep study, unattended, simultaneous recording minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone) [3 no sleep].

### Characteristics of Portable Sleep Devices

- Measure sleep time
- Respiratory belts vs indirect measures of effort
- Event detection: Flow/effort vs PAT vs venous flow
- Ease of patient application
- Raw data review
- Automated vs manual scoring
- Artifact rate
- Initial cost
- Per patient cost of disposables

### HST Valuation 2011-2014 @$34.04

<table>
<thead>
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<td>95806</td>
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</table>

Max difference = 2.35 RVU = about $80. (2014: 1 RVU = $34.)
Difference in per patient costs may be lower than that.
Unstable relative pricing & coding. (Practice expenses changes.)
### Sleep Testing Ofc & Hosp OP CMS Natl Avg Payment 2014

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2011 RVU</th>
<th>2014 APC</th>
<th>2014 CMS Payment</th>
<th>2014 CMS OPPS</th>
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<tbody>
<tr>
<td>95800</td>
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<td>213</td>
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<td>$173</td>
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<td>95801</td>
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<td>213</td>
<td>$91</td>
<td>$173</td>
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<td>95803</td>
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<td>218</td>
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<td>$80</td>
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<td>95805</td>
<td>Multiple Sleep latency test</td>
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<td>209</td>
<td>$402</td>
<td>$800</td>
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<td>95806</td>
<td>Sleep study unattd resp efft</td>
<td>5.38</td>
<td>213</td>
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<td>95807</td>
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<td>95808</td>
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<td>95810</td>
<td>Polysonmography 4 or more</td>
<td>20.51</td>
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<td>$590</td>
<td>$800</td>
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<tr>
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<td>209</td>
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<td>22.13</td>
<td>209</td>
<td>$619</td>
<td>$800</td>
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</table>

- Assumes conversion factor $34.04
- Hospital TC payment equal for PSGs, equal for HSTs. (Prof fee varies.)
- Peds PSG higher due to 1:1 tech ratio.

### HST Regulatory/Policy Issues

- HST = diagnostic testing. (CMS covers screening tests only if required by law, eg mammography.)
- Many CMS requirements are the same as for PSG:
  - In some regions, credentials for MD and Tech, facility accreditation, even in MD office!!
  - State licensing likely to be the same for techs providing unattended studies as for attended studies
- Many insurers now require HST as default, with pre-authorization for PSG.

### Medicare: HST Regulatory/Policy

- **Document:**
  - Patient is seen face to face.
  - Screening questionnaire completed.
  - Staff measures head & personally instructs patient.
  - Paper instructions included with every test.
- Not just casual mail-out or handoff!

### PSG and HST Policies:

- Some coverage PSG for morbid obesity and insomnia.
- OIG auditing sleep testing, particularly correct use of modifiers and duplicative testing.
- Check your local Medicare carrier and other insurer policies!
HST/Sleep Tech Regulatory Issues
Which licensed tech privileges /duties may be performed by nonlicensed personnel? Local regulations are evolving!!

- OOCT by mail:
  - No personnel interact directly with the patient.

- OOCT through office:
  - Patient education
  - Analysis of recording
  - Application of electrodes (possible)

Medicare and PAP

- “No aspect of an HST, including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests.” Cigna DMAC LCD 2012

HST: Whom Can You Test:

- Does the insurer require:
  - Facility accreditation?
  - Face to face visit to dispense?
  - Registered/licensed tech?
  - Interp by board-cert MD?
  - Interp by board-cert MD for CPAP?
  - Separation of testing and DME
  - Review antimarkup limitations

OOCT Considerations
Anti-Markup Payment Limitation

- A doctor orders a diagnostic test (excluding clinical diagnostic laboratory tests) and bills for TC or PC that is performed or supervised by a supplier who does not “share a practice:”

- Payment to the billing MD for the purchased TC or PC is the lowest of
  - The performing supplier’s net charge (can’t add space or equip leased by the billing MD.)
  - The billing MD’s actual charge
  - Allowed fee schedule amount
**OOCT Considerations**

**Anti-Markup Payment Limitation**

- Anti-markup payment limitation does not apply:
  - To independent laboratories
  - If the performing MD ‘shares a practice’ with the ordering/billing MD.

- Local LCDs: “hodgepodge,” but becoming more uniform with fewer MACs.
- Consider when contracting to do interps.

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**Sleep Medicine: Strategies for Change**

**Integrated Sleep Center: the Pack Proposal**

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- **Pack, J Clin Sleep Med Dec 2011**

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**Non-physician providers**

- Physician Assistants, Nurse Practitioners
- CMS pays about 85% of MD fee schedule
- 2013: G code for MD letter if PA/NP does FTF visit
- Practice benefits: Practice expansion, availability.
- Concerns: Specialty training, fiscal responsibility.

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Sleep Treatment Dispensing

- CPAP and Oral Appliances are Durable Medical Equipment (DME).
- Physician obstacles to DME dispensing: Federal and State self-referral regulations.
- Dentists rarely have DME contracts with insurers, and few register as CMS DME providers.

CMS CPAP Payment Requirements:

- Pre-test MD visit
- Test read by qualified MD
- Test done in accredited facility, even if HST
- AHI ≥5 if symptomatic, AHI ≥15 if not symptomatic
- Post-Rx MD visit in month 2 or 3
  - Symptoms improve;
  - Objective adherence 4 hours, 70% of 30 nights
- Patients failing compliance test need new PSG! NOT HST!!
  - [Not required: in-lab titration]

CMS BPAP Payment Requirements (2010)

- …unsuccessful with attempts to use CPAP and
- “Multiple interface options have been tried and the current interface is most comfortable…” and
- “The work of exhalation (emphasis added) with the current pressure setting” prevents patient tolerance and
- Lower pressures don’t control symptoms or reduce AHI/RDI to acceptable level.

Auto-PAP

- No separate code for auto-CPAP or auto-BPAP.
- Patients and insurers do not pay more for auto-PAP than PAP.
- Autos add $25-50 to DME provider cost.
Medicare and PAP: 2009 Audit
- 100 claims by 96 providers
- Error rate: 64% of payments
- DME is largest area of payment errors for CMS
  - (Is this because compliance with the regulations is impossible?)

Medicare and PAP
- Practical approach to scoring/reporting:
  - Score apneas, hypopneas, and RERAs separately.
  - Report RDI and AHI.
- Document symptoms at baseline.
- 2013: G code for MD letter if PA/NP does FTF visit
- Document CPAP expiratory intolerance.
- Advance notice to pts: 90 day trial to document:
  - Symptomatic improvement
  - Adherence; how to get the info – MD, DME or self-check

Medicare and PAP
- Equipment refills: must specify frequency of replacement.
- “Blanket order,” not individual, may not be accepted

RX: ☑ INCLUDE OR ☐ REPLACE PRN FOR 12 MONTHS:
- A7027 Oro/Nasal Mask 1per3Mo
- A7028 Oral Cush Repl 2perMo
- A7029 Nasal Pillow Repl 2perMo
- A7030 Full Face Mask 1par3Mo
- A7031 FF Mask Cush Repl 1perMo
- A7032 Nasal Cush Repl 2perMo
- A7033 Nasal Pillow Repl 2perMo
- A7034 Nasal Interface Mask 1per3Mo
- A7035 Headgear 1per6Mo

E0485: Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment.

E0486: Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment.

90% patient coverage in some markets.

Dentists providing HST should review state scope of practice. In most cases a physician should interpret the study.
Oral Appliance: CMS DME LCD Feb 2011

- F2F visit with MD before sleep testing.
- Sleep test documents need for therapy
- PAP intolerant or contraindicated.
- OAT ordered by the treating physician following review of the report of the sleep test.
- The device is provided and billed for by a licensed dentist (DDS or DMD).
- Custom fabricated device is covered: E0486.
- For 2011: fee schedule $1,291.

Trends in Sleep Apnea Surgery:
Kezerian et al 2010

- Databases: National Inpatient Sample and 4 States
- Estimated total procedures in 2006: 35,000
  - 0.2% of pts with OSA annually have surgery
  - Over 75% of procedures were isolated palate.
  - Majority of procedures were outpatient.

Medicare Surg Fees 2012 (90 day global)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>CMS Facility Payment 2012</th>
<th>Global period</th>
</tr>
</thead>
<tbody>
<tr>
<td>21146</td>
<td>LeFort 1, 2 pieces, requiring bone grafts</td>
<td>$1,758</td>
<td>90</td>
</tr>
<tr>
<td>41512</td>
<td>Tongue base suspension, permanent suture</td>
<td>$641</td>
<td>90</td>
</tr>
<tr>
<td>41530</td>
<td>Submucosal ablation tongue base, radiofrequency, 1 or more sites, per session</td>
<td>$418</td>
<td>10</td>
</tr>
<tr>
<td>42145</td>
<td>Repair palate, pharynx/uvula</td>
<td>$724</td>
<td>90</td>
</tr>
<tr>
<td>42825</td>
<td>Removal of tonsils</td>
<td>$250</td>
<td>90</td>
</tr>
</tbody>
</table>

CMS Sleep Apnea Surgical Policies

- UPPP eligible for coverage when all of following:
  - OSA dx certified sleep disorder lab (AASM)
    - No discrimination against portable monitoring
  - RDI of 15 or higher
  - Failed to respond/tolerate CPAP
  - Documented counseling by MD with recognized training in sleep disorders: potential benefits and risks of surgery
  - Evidence of retropalatal or combination retropalatal/retrolingual obstruction as OSA cause.
- MMA requirements similar
- Rare coverage for other treatment methods
Bariatric Surgery Indications

- United Health Care: Bariatric surgery proven for Class II obesity (BMI 35-39.9) with 1 of 5 comorbidities including AHI or RDI over 30
- Aetna: RYGB medically necessary for BMI 35 with 1 of 4 comorbidities including AHI defined similar to CMS criteria.
- Medicare NCD: BMI > 35, have at least one comorbidity related to obesity.

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Where to Embed Sleep Medicine?

- Outpatient practices:
  - Primary care
  - Cardiology, Vascular surgery, Stroke
  - Screening protocol for outpatient surgery
- Inpatient service for
  - Periop care
  - Inpt rapid Dx and Tx pathway to PAP
- OOCT may play large role

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### PQRS Incentives and Penalties

<table>
<thead>
<tr>
<th>Year</th>
<th>Incentive</th>
</tr>
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<tbody>
<tr>
<td>2013</td>
<td>0.5% if no MoC, 1% if MoC (performance year for 2015 penalty)</td>
</tr>
<tr>
<td>2014</td>
<td>0.50%</td>
</tr>
<tr>
<td>2015</td>
<td>-1.50%</td>
</tr>
<tr>
<td>2016</td>
<td>-2%</td>
</tr>
</tbody>
</table>

*See CMS payment adjustment tool*

### PQRS Adds Sleep Apnea Measure 2012

- **G8900:** I intend to report the Sleep Apnea measures group (Registry Only).
  - [Report this code once only.]
- PQRS Measures in Sleep Apnea measures group includes:
  - #276 Sleep Apnea: Assessment of Sleep Symptoms
  - #277 Sleep Apnea: Severity Assessment at Initial Dx
  - #278 Sleep Apnea: PAP Therapy Prescribed
  - #279 Sleep Apnea: Assessment of Adherence to PAP

### PQRS Adds Sleep Apnea Measure 2012

- **20 Patient Sample Method:**
  - 20 unique patients, majority Medicare Part B FFS
  - Reporting period 1/1-12/31/13 or 7/1-21/31/13
  - Measure only 1 visit/pt during the reporting period, not every visit.
  - Report all measures within the Sleep Apnea Measures Group for each pt in the sample.
  - The recommended clinical quality action must be performed on at least one patient for each measure.

- **#276 Sleep Apnea: Assessment of Sleep Symptoms**
  - Sleep apnea symptoms assessed, including presence or absence of snoring and daytime sleepiness OR
  - Documentation of reason(s) not measured eg, patient didn’t have initial daytime sleepiness, patient visits between initial testing and initiation of therapy [OR not done]

- **#277 Sleep Apnea: Severity Assessment at Initial Dx**
  - AHI or RDI measured at the time of initial diagnosis OR
  - Reason not measured eg, abnormal anatomy, patient declined, financial, insurance coverage) [OR not done]
PQRS Adds Sleep Apnea Measure 2012

- #278 Sleep Apnea: PAP Therapy Prescribed
  - Pts with mod/severe OSA (AHI or RDI 15 or more); Rx'd PAP OR
  - AHI/RDI under 15 OR
  - Documented reason for no RX eg patient unable to tolerate, alternative therapies used, patient declined, financial, insurance coverage. [OR not done]

- #279 Sleep Apnea: Assessment of PAP Adherence
  - PAP prescribed, adherence objectively measured, defined as PAP machine-generated measurement of hours of use.
  - Documentation of reason(s) for not objectively measuring adherence eg., patient didn’t bring data, therapy not yet initiated, not available on machine. [OR not done]

Sleep Data Transactions

- Best quality measures yet to be defined for sleep medicine; pretty good for OSA.
- Standards needed: How to combine data from patient questionnaires, physician visits, DME visits, adherence/efficacy data.

PQRS Adds Sleep Apnea Measure 2012

- 20 Patient Sample Method:
  - 20 unique patients, majority Medicare Part B FFS
  - Reporting period 1/1-31/13 or 7/1-31/13
  - Measure only 1 visit/pt during the reporting period, not every visit.
  - Report all measures within the Sleep Apnea Measures Group for each pt in the sample.
  - The recommended clinical quality action must be performed on at least one patient for each measure.

Barriers to Integrated Sleep Medicine

- Doctors can’t dispense DME. (Although Patients see the doctor as responsible for DME provider performance.)
- A company providing any part of HST can’t provide DME. (Hospitals excepted.)
- Co-location rules prohibit DME company from sharing space with another Medicare provider – such as physician.
- Large ACOs will include physician specialties, but NOT dentists or DME.
PSG Valuation 2008-2013

<table>
<thead>
<tr>
<th>CPT</th>
<th>Mod</th>
<th>Description</th>
<th>Total RVU 2008</th>
<th>Total RVU 2013</th>
<th>RVU Change 2008-2013</th>
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<tbody>
<tr>
<td>95810</td>
<td>TC</td>
<td>PSG 4 or more</td>
<td>21.69</td>
<td>18.99</td>
<td>-12%</td>
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<tr>
<td>95810</td>
<td>26</td>
<td>PSG 4 or more</td>
<td>16.96</td>
<td>15.47</td>
<td>-9%</td>
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<tr>
<td>95810</td>
<td></td>
<td></td>
<td>4.73</td>
<td>3.52</td>
<td>-26%</td>
</tr>
<tr>
<td>95811</td>
<td>TC</td>
<td>PSG w/cpap</td>
<td>23.82</td>
<td>19.92</td>
<td>-16%</td>
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<tr>
<td>95811</td>
<td>26</td>
<td>PSG w/cpap</td>
<td>18.74</td>
<td>16.26</td>
<td>-13%</td>
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<td></td>
<td>5.08</td>
<td>3.66</td>
<td>-28%</td>
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</tbody>
</table>

MD work includes page-by-page review by MD!!! Estimated 66.5 min of MD time.

Growth in PSG normalized to 1998

Growth in PSG and OOCT (x20)
Does CMS Payment Change Patient Outcomes?

- Reduced patient access to care is not the same as patient outcome.
- If outcomes suffer as a result of reduced payment and reduced access, THEN CMS would have to reconsider.
- ACO structures are only now developing. DME providers may not participate in ACOs.

Lowering cost of Performing PSG

- Salary: techs score PSGs as they go?
  - Can a recording tech score/study 3 patients?
    - Improve safety: Automatic monitoring EKG, SpO2
    - Use autoPAP for titration, split-night studies
  - Can scoring techs work faster?
    - ? Scoring software
    - ? Partial scoring for severe OSA and for PAP titration

- Facility rent
  - Double-use rooms: Murphy bed and desk
    - Note: IDTF can’t share space with another entity that bills CMS
  - Use rooms during the day: HST!!

HST Process

- Old model:
  - Practice purchases equipment and per procedure disposables, pays tech to score, completes interp letter.
- New model:
  - Practice pays monthly fee for service which includes use of diagnostic device, all disposables, hosted cloud service to store and score data and prepare interp letter.

<table>
<thead>
<tr>
<th>2014: Monthly Profit/Loss HST 95900</th>
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<tbody>
<tr>
<td>Tests/month</td>
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<tr>
<td>Technical income per test</td>
</tr>
<tr>
<td><strong>Gross monthly technical income</strong></td>
</tr>
<tr>
<td>Monthly rental</td>
</tr>
<tr>
<td>Per study staff time about 1 hour</td>
</tr>
<tr>
<td><strong>Total monthly staff time</strong></td>
</tr>
<tr>
<td>Total monthly costs</td>
</tr>
<tr>
<td><strong>Net monthly technical income</strong></td>
</tr>
<tr>
<td>Gross monthly prof income @$53</td>
</tr>
<tr>
<td>Net monthly income to practice</td>
</tr>
<tr>
<td><strong>Net income to practice per test</strong></td>
</tr>
</tbody>
</table>
Max difference = 2.35 RVU = about $80.
Difference in per patient costs may be lower than that.
Unstable relative pricing and coding.

Novitas LCD L27530 - Sleep Disorders Testing Draft LCD 2013-2014
- Jurisdiction: P, DE, DC, NJ
- Not covered for comorbidities incl mod-sev pulm dis, neuromuscular disease, CHF, PLMs, insomnia, parasomnias
- 3 nights testing required
- For all sleep tests: Board-cert MD director, Accredited facility, “Experienced” tech with “face to face meeting for application and education” (?licensed)

OIG: PSG Study Oct 2013
- 2011 claims. 6,339 providers with 3 or more claims
- Hospital outpt claims:
  - 53% of claims
  - 85% of claims without appropriate dx code
- Of 6,339 providers:
  - 180 (2.85) with patterns of questionable billing
  - Account for 3.7% of payments
My Practice Plan

- Continue private practice solo
  - I do not own a testing facility.
  - I lease 3 HST devices.
  - Attempt to replace PSG volume with 3x as many HST.
- Introduce HST to local PCP groups
  - They can perform tests and bill technical component.
  - I will interpret tests.
  - I will train MD, NP, PA to handle routine OSA/PAP Rx.
  - I will treat patients with difficult problems.
- Continue as consultant to NIH and local VAMC.

To Do in 2014:

- Make the PSG balance sheet positive.
- Put HST into a part of your practice.
- Plan to be part of integrated care.
- Negotiate now with your local insurers: integrated sleep care.

GET IN THE GAME!

- AASM Health Policy Committee needs your support at AMA & its committees.
- Support the AASM Political Action Committee (PAC).
- State medical societies are needed to:
  - Meet with CMS Local carriers and providers.
  - Establish and protect sleep technology as an independent health profession.
References

- Medicare 2014 Physician Fee Schedule
- Medicare 2014 Hosp Outpatient Prospective Payment System
- Medicare coverage database for NCDs and LCDs

References cont

- United healthcare bariatric surgery
- Aetna Clinical Policy Bulletin
  - http://www.aetna.com/cpb/medical/data/100_199/0157.html
- Medicare bariatric surgery NCD:

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- United healthcare sleep apnea surgery
- Aetna Clinical Policy Bulletin
  - http://www.aetna.com/cpb/medical/data/100_199/0157.html
- Medicare bariatric surgery NCD:
- CMS payment adjustment tool:
  - http://www.cms.gov/eHealth/downloads/PaymentAdjustmentT ool_20130912_FINAL.pdf

References cont

- Medicare Portable monitoring decision 2008:
- Medicare Portable monitoring technology assessment: