Reimbursement for Sleep Testing and Treatment

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Marc Raphaelson, MD

CONFLICT OF INTEREST DISCLOSURES

Type of Potential Conflict	Details of Potential Conflict
Consultant	Jazz (Xyrem)
Speakers' Bureaus	Jazz (Xyrem)
Other	Affiliated with SleepMed Inc
	SleepMed owns WaterMark, a manufacturer of a home sleep testing device and service.

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	■ 95808 **Polysomnography**; *any age*, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	■ 95782 **Polysomnography**; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
■ 95806 **Sleep study**, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist	■ 95810 **Polysomnography**; *age 6 years or older*, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	■ 95783 **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
■ 95807 **Sleep study**, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	■ 95811 **Polysomnography**; *age 6 years or older*, 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	■ 95703 **Actigraphy testing,** recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)

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]*
- 95806 **Sleep study**, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist *[4 including effort+flow]*
- (95800: TST meas. directly or indirectly (arterial tonometry, actigraphy)
- (Do not unbundle. Do not report actigraphy, Holter, etc.)
- (6 hours of monitoring. If not, use -52 modifier.)
- Some carriers are still paying only for the older G codes: G0399 for 95800.

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

CPT	2011 RVU	Total RVU 2012	Total RVU 2013	Proposed 2014	Proposed 2014
95806	5.38	**5.4**	**5.39**	4.83	**$ 164**
(4 w effort/FLOW)	3.53	3.58	3.60	3.08	
-26 (Prof)	1.85	1.82	1.79	1.75	**$ 60**
95800	**6.05**	4.73	5.37	**5.01**	**$ 171**
(3+sleep)	4.34	3.25	3.87	3.53	
-26 (Prof)	1.71	1.48	1.29	1.48	**$ 50**
95801	2.85	2.54	2.80	2.66	**$ 91**
(3 no sleep)	1.34	1.13	1.40	1.39	
-26 (Prof)	1.51	1.41	1.40	1.27	**$ 43**

- 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

CPT	Description	2011 RVU	Total RVU 2014	APC	2014 CMS Payment	2014 CMS OPPS
95800	Sleep stdy unattended	6.05	5.01	213	$171	$173
95801	Sleep stdy unatnd w/anal	2.85	2.66	213	$91	$173
95803	Actigraphy testing	4.78	4.22	218	$144	$80
95805	Multiple sleep latency test	12.12	11.81	209	$402	$806
95806	Sleep study unatt&resp efft	5.38	4.83	213	$164	$173
95807	Sleep study attended	13.88	13.3	209	$453	$806
95808	Polysomnography 1-3	19.19	17.83	209	$607	$806
95810	Polysomnography 4 or more	20.51	17.34	209	$590	$806
95811	Polysomnography w/cpap	22.13	18.19	209	$619	$806
95782	Polysomnography 4 or more, < 6yo	20.51	28.65	?	$975	?
95783	Polysomnography w/cpap , <6yo	22.13	30.54	?	$1,040	?

- 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 equipt 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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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	A7036	Chinstrap	1per6Mo
A7028	Oral Cush Repl	2perMo	A7037	Tubing for PAP	1per3Mo
A7029	Nasal Pillows Repl	2perMo	A7038	Filter Disposable	2perMo
A7030	Full Face Mask	1per3Mo	A7039	Filter Nondisposable	1per6Mo
A7031	FF Mask Cush Repl	1perMo	A7044	Oral Interface	1per3Mo
A7032	Nasal Cush Repl	2perMo	A7045	Exhalation Port Repl	NA
A7033	Nasal Pilllows Repl	2perMo	A7046	Water Chamber	1per6Mo
A7034	Nasal Interface Mask	1per3Mo	A4604	Tubing w Integ Heat	1per3Mo
A7035	Headgear	1per6Mo			

Oral Appliance HCPCS Codes = DME

- 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)

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

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 comorbiities 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 co-morbidity 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	
2013	0.5% if no MoC, 1% if MoC (performance year for 2015 penalty)
2014	0.50%
2015	-1.50%
2016	-2%

- 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.

PQRS Adds Sleep Apnea Measure 2012

- #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]

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  - 20 unique patients, majority Medicare Part B FFS
  - Reporting period 1/1-12/31/13 or 7/1-21/31/13
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  - 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.

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.

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

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

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

The Boston Globe

Health & wellness

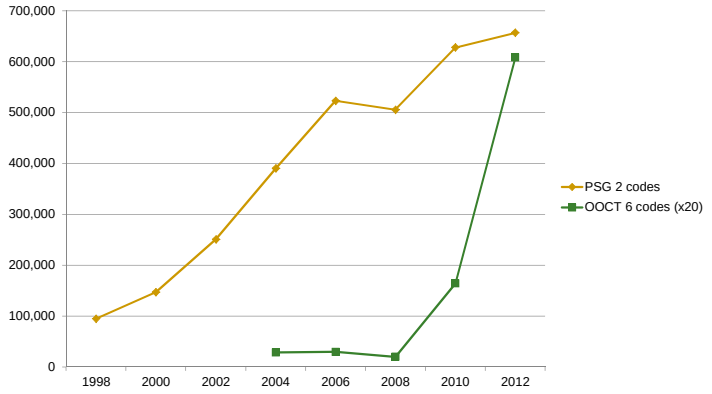
All 19 Sleep HealthCenters clinics close abruptly

By Chelsea Conaboy | GLOBE STAFF JANUARY 26, 2013

Sleep HealthCenters, a for-profit chain of sleep clinics mostly in New England, abruptly closed this week, leaving some patients who showed up for appointments facing locked doors and a closure notice citing "circumstances beyond our control."

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.

2014: Monthly Profit/Loss HST 95900

Tests/month	8
Technical income per test	$126
Gross monthly technical income	**$1,008**
Monthly rental	($300)
Per study staff time about 1 hour	($25)
Total monthly staff time	($200)
Total monthly costs	**($500)**
Net monthly technical income	$508
Gross monthly prof income @$53	$432
Net monthly income to practice	$940
Net income to practice per test	$118

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Novitas LCD L27530 - Sleep Disorders Testing Draft LCD 2013-2014

- Jurisdiction: P, DE, DC, NJ
- Not covered for comobidities incl mod-sev pulm dis, neuuromuscular 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)

Novitas LCD L27530 - Sleep Disorders Testing Draft LCD 2013-2014

- Jurisdiction: P, DE, DC, NJ
- “The notes must clearly indicate the patient has a high likelihood of having moderate to severe sleep apnea.”
- WatchPat shall be billed as CPT code 95801. Our review found that actigraphy was not a sufficiently accurate substitute measure of sleep time to recommend its routine use.

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

Florida-Based American Sleep Medicine To Pay $15.3 Million For Improperly Billing Medicare And Other Federal Healthcare Programs

THURSDAY, 03 JANUARY 2013 15:48 PRESS RELEASE POLICE REPORT

(0 Votes)

Facilities In Alabama, California, Delaware, Florida, Illinois, Indiana, Kansas, Kentucky, Maryland, Missouri, New Jersey, Tennessee, Texas And Virginia

Washington DC--(ENEWSPF)--January 3, 2013. Florida-based American Sleep Medicine LLC has agreed to pay $15,301,341 to resolve allegations that it billed Medicare, TRICARE – the health care program for Uniformed Service members, retirees and their families worldwide -- and the Railroad Retirement Medicare Program for sleep diagnostic services that were not eligible for payment, the Justice Department announced today.

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.

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