CHEST

Evolution in Reimbursement for Sleep Studies and Sleep Centers

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Because of the rapid increase in the volume and costs of polysomnography and other sleep medicine diagnostic services, the Centers for Medicare & Medicaid Services (CMS) recently commissioned the Office of Inspector General (OIG) to review claims submitted for these services. The OIG found numerous cases of inappropriate payment for submitted claims and recommended significant changes in the CMS auditing process for polysomnography claims review. Additionally, a local Medicare Administrative Contractor released the most specific rules and regulations to date regarding billing and payment for sleep medicine services. These regulations specify covered diagnoses for submitted claims for both facility-based polysomnograms and unattended home sleep tests (HSTs) and list noncovered diagnoses that cannot be used to document medical necessity for such studies. The proposed rules specify minimum credentials for technologists performing polysomnograms and HSTs, mandate education prior to application of HST devices, demand a follow-up visit to discuss results after studies, and elaborate new requirements for physicians interpreting these studies. Providers of sleep medicine services must be prepared to provide documentation of diagnoses and indications when submitting claims for sleep services, and they can expect to be required to produce evidence of accreditation of the physicians and technologists providing services and the credentials of the sleep center. These changes will dramatically affect sleep medicine practitioners who order sleep studies and positive airway pressure therapies. Successful sleep medicine centers and sleep physicians alike will need to develop strategies to meet these new challenges.

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ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; HST = home sleep test; ICD-9 = *International Classification of Diseases, Ninth Revision*; LCD = local coverage determination; MAC = Medicare Administrative Contractor; NPI = National Provider Identification; OIG = Office of Inspector General; OSAHS = OSA-hypopnea syndrome; PAP = positive airway pressure; PSG = polysomnography

The high prevalence of OSA-hypopnea syndrome (OSAHS)[1] and its associated costs of diagnosis and therapy have led to significant changes and controversies in recent years regarding the use of diagnostic polysomnography (PSG) and prescription of positive airway pressure (PAP) therapy. Knowledge about the health-related consequences associated with OSAHS continues to increase at a dramatic rate. OSAHS is a

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major risk factor for hypertension and many forms of cardiovascular disease, including heart failure and atrial fibrillation.[2,3] The significant increase in the incidence of obesity and other risk factors for OSAHS, combined with increased awareness by physicians and the public, has led to more referrals for evaluation of OSAHS and more sleep studies in the past 15 years[1] (Fig 1, Table 1).

Attempting to reduce the financial impact of PSGs and treatment of OSAHS with PAP by eliminating unnecessary, wasteful, and fraudulent payments, the Centers for Medicare & Medicaid Services (CMS) implemented policies to reduce diagnostic facility-based PSGs and maximize treatment in adherent patients who would benefit from therapy. In 2008, CMS first allowed unattended, portable, diagnostic home sleep test (HST) results to qualify patients for reimbursement of PAP treatment.[5] Notably, this determination occurred when many in the scientific community remained unconvinced that HSTs were sufficiently valid and reliable to be used diagnostically.[6-8] In parallel to these changes by CMS, many commercial payers instituted policies mandating both HST for diagnosis of OSAHS and auto-adjusting PAP for therapy, thereby limiting the use of PSG to patients with comorbidities.[9-11] These changes precipitated widespread use of HST for diagnostic testing for OSAHS, in lieu of facility-based PSGs. Such shifts have been dramatic in some areas, and they have precipitated closure of sleep medicine centers.[12]

Paralleling the shift in site of service for diagnostic testing, the certification of providers necessary to interpret sleep studies (including HST) is being defined by CMS regulations. Although Medicare payment policy requires board certification in sleep medicine for interpretation of sleep studies (facility- and home-based tests),[5] these policies remain controversial.[13-16]

These policy changes by both CMS and commercial payers portend fundamental modifications in the delivery of diagnostic and therapeutic services for OSAHS. Recently, the Office of Inspector General (OIG) published its findings from a targeted examination of paid PSG claims. Also, a Medicare Administrative Contractor (MAC), Novitas Solutions, updated its local coverage determination (LCD) with new requirements for the diagnosis and treatment of Medicare patients with OSAHS and other sleep disorders. We provide background and guidance on these current trends of increased oversight of OSAHS management that create evolutionary pressures on the practice of sleep medicine.

OIG Review of PSG Payments

Due to increases in volume over the past decade, PSG services have gained the attention of CMS. Medicare payments for PSG services increased by 39% between 2005 and 2011 (Fig 1), and in 2011, CMS paid $>$1 million PSG claims that totaled $>$\$565 million.[17] The rising number of PSGs, associated costs, and concerns about fraud led CMS to request that the OIG perform a review. The OIG completed a targeted examination of claims for PSG services performed in 2011 for medical necessity and appropriateness of billing. The OIG report "Questionable Billing for Polysomnography Services"[17] was released in October 2013. Using 11 measures of appropriateness, they found approximately \$17 million was paid for PSG services that did not meet one or more of the measures. These inappropriate payments represented $<$3% of all PSG claims, with inappropriate (but not necessarily fraudulent) diagnostic codes representing the

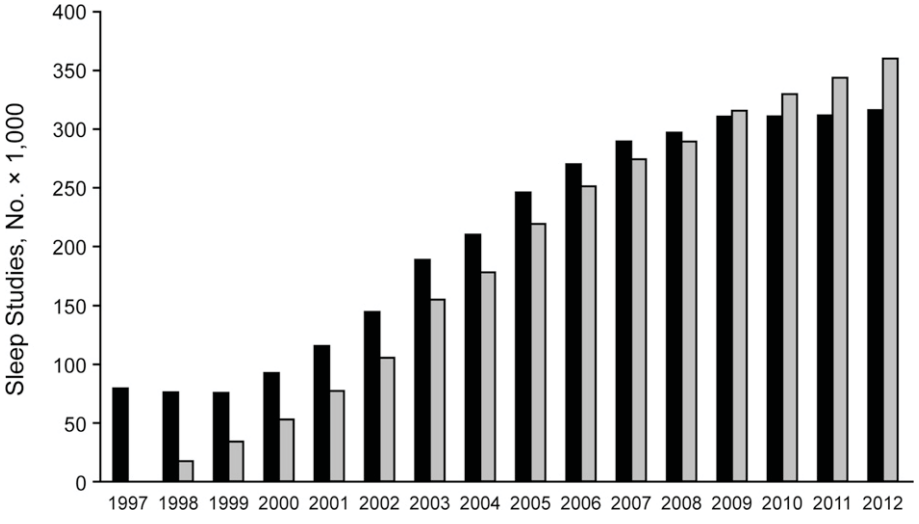

Figure 1 – *Rapid increase in polysomnography services, 1997-2012. Dark bar indicates code 95810; gray bar, code 95811.*[4]