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Home Testing Demystification

Sleep Review - March 2010

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Reading into changes in the sleep medicine business and regulatory environment.

A variety of new challenges—and ripe opportunities—await sleep industry participants as the new decade dawns. The regulatory and business trends shaping up in 2010 and beyond are geared to change the sleep medicine landscape



HOME TESTING GETS ITS LEGS

The promise of cheaper, quicker, and efficient detection of obstructive sleep apnea through home testing is here. But the mystery surrounding how best to incorporate portable monitoring into existing sleep lab programs and general physician practices remains.

Most sleep medicine specialists and lab operators know the practical challenges presented by home testing. They face a marketplace fragmented by conflicting payor rules and varying physician standards. Newcomers to the field, such as family practitioners and other nonsleep specialists, need to be aware of these hurdles as well.

For example, Medicare's reimbursement rules dictate that a qualified sleep physician must interpret the home test (and, beginning this year, the full in-lab PSG test as well) as a condition to Medicare PAP coverage. Medicare will also limit the use of home testing to persons who, following a physician examination, are free of certain co-morbid conditions.



To alleviate perceived overutilization concerns, the Centers for Medicare and Medicaid Services (CMS) will not pay for a PAP device if the supplier of the PAP is affiliated with the person or entity performing the home sleep test.

Practical concerns don't stop with Medicare reimbursement. The commercial insurance environment can be just as limiting to home sleep testing in certain respects. Those exploring home testing in general should ask themselves some of the questions set out below.

How Do I Bill the Thing? The CPT Overhaul for Home Sleep Tests

Most providers of the home sleep test bill the study under CPT Code 95806 or the applicable HCPCS G-Code (G0398, G0399, or G0400). Effective January 1, 2010, the American Medical Association, as publisher of CPT codes, introduced changes to the home sleep test codes.

First, the AMA revised its description of the long-standing CPT Code 95806. The 2010 revision seems little more than a tweak. Originally, the narrative referred to a "Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist."

The revision rearranges the criteria, deletes the reference to "ECG," adds the terms "respiratory

airflow" in lieu of "ventilation," and boosts the description of "respiratory effort" by reference to thoracoabdominal movement. In full, the revised CPT 95806 provides: "95806 Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)."

Next, the AMA added two new Category III, or "temporary" codes to describe the home sleep test. Category III codes are for emerging technologies, services, and procedures. They are temporary in that they have an expected useful life of 5 years. Category III codes are typically converted to the fully recognized Category I CPT codes within the 5-year period.

In full, the service descriptors for the newly introduced T-Codes are:

0203T Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone) and sleep time.

0204T Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone).

The AMA's revision of 95806 adds specific references to respiratory airflow and chest and abdominal movement as separate measures of sleep respiration. Contrast these direct respiratory measures with the T-Codes' reference to the indirect "respiratory analysis" measurement. The purpose of the 95806 revision may be to distinguish use of the direct respiratory signals from the more liberal, indirect channels referenced in the T-Codes.

But the big news in the AMA's relook at home sleep codes may be its rejection of the four measurement "Type" classifications long recognized for home sleep testing. As noted by Cigna's Medical Coverage Policy for Obstructive Sleep Apnea, the Type I, Type II, Type III, and Type IV classification "is no longer entirely clear, however, because of the recent proliferation of devices that measure various parameters and do not necessarily fit into the above categories."

Instead of historical "Type" definitions, the AMA adopts for its T-Codes the broadest range of recording measures described in both the CMS National Coverage Decision Memorandum for OSA sleep testing and the existing G-Code G0400. By publishing these T-Codes, the AMA appears to ignore the distinctions among Types and bless the most expansive, and perhaps least expensive, measure. Whether the T-Codes take hold and drive all home test reimbursement to the lowest common denominator remains to be seen.

Introduction of the T-Codes does not effect any immediate change. The home test G-Codes (G0398, G0399, and G0400) remain in use. Neither CMS nor any commercial carrier has assigned any valuations or dollars to these T-Codes, and they may not during the temporary period.

But movement away from exact references to four home test "Types" toward any method measuring a minimum of three channels (heart rate, oxygen saturation, and respiratory analysis) may have started.

Does My Sleep Program Need Special Accreditation?

Nonsleep specialists seeking entry into the home test business may find it easy to locate a qualified sleep physician to read Medicare home tests as required by Medicare reimbursement rules. But local Medicare contractors may require more of the newcomer's sleep disorders program.

For example, the Medicare Part B Contractor for Florida, First Coast Option Services, adopted a Local Coverage Determination for sleep testing last year. It provides that a home sleep test is covered as medically necessary only if the home test provider is accredited by the American Academy of Sleep Medicine or The Joint Commission

First Coast makes clear that the accreditation requirement extends to physician practices performing sleep tests on their own patients. Because AASM accreditation requires the participation of a certified sleep physician as part of the sleep disorders program, physician practices performing Medicare home tests in selected jurisdictions will need to affiliate with a credentialed sleep physician at least for medical director services

Beginning January 1, 2011, TrailBlazer Health Enterprises, LLC, the Medicare Contractor for Texas, New Mexico, Oklahoma, and Colorado, will also require accreditation for all nonhospital providers of Medicare sleep tests as a condition of payment. Other Medicare contractors also require accreditation of the sleep program as condition to Medicare reimbursement.

Will Commercial Carriers Reimburse the Home Test?

Not all commercial insurance carriers reimburse the home test at this time. For example, according to their currently available medical policies, Blue Cross Blue Shield of Florida and Blue Cross Blue Shield of Mississippi will not cover home sleep testing at this time. Each considers the service investigational. Likewise, Priority Health does not cover home sleep tests.

Cigna HealthCare's Medical Coverage Policy for Obstructive Sleep Apnea provides home test coverage only when Type II or Type III devices are used. North Carolina Blue Cross Blue Shield covers home sleep tests only if the physician who interprets and bills the unattended sleep study has the same qualifications required by Medicare for the professional interpretation of home sleep tests.

According to Policy #129 of Massachusetts Blue Cross Blue Shield, coverage for home sleep testing applies only to services billed as CPT Code 95806 or G0399. The Massachusetts carrier does not cover tests billed as G0398, G0400, 0203I, and 0204T. The carrier says that these services fail to meet Massachusetts Blue Cross Blue Shield's Medical Technology Assessment Guidelines.

Customer Channel Conundrums for PAP Suppliers

The good news for PAP suppliers in home testing is the potential expansion of their referral base. First-time participants in sleep testing, such as family practitioners and other nontraditional sleep test providers, can be a new source of PAP business. But unexpected consequences can follow as the referral base expands.

Consider a common situation involving a family practitioner, an ENT sleep specialist, and a PAP supplier. The family practitioner historically refers sleep disorders patients to the ENT practice for sleep testing and follow-up. Having found the PAP supplier to be a caring, competent, and diligent patient care provider, the ENT routinely refers his sleep patients to the PAP supplier for OSA treatment.

The family practitioner comes across home sleep testing and interrupts this routine. He performs home tests on his patients where appropriate and sends his other sleep patients to the ENT specialist. Upon a finding of positive OSA, the family practitioner refers his patients directly to the PAP supplier for PAP therapy.

Sometime later, the ENT sleep specialist discovers why his referrals from the family doctor are down. Then the ENT specialist finds out that the PAP supplier is benefitting from the family doctor's new sleep business. The PAP supplier may find himself in an unexpectedly sticky situation vis-a-vis his old friend the ENT specialist when the two next meet.

FRAUD AND ABUSE RISKS REMAIN

President Obama has budgeted more than \$1.5 billion in fiscal year 2011 to boost efforts to fight fraud and abuse in the Medicare and Medicaid programs. Sleep testing and PAP therapy remain exposed to Medicare fraud and abuse investigations. This is particularly so in light of the government's increased enforcement efforts and billing errors in sleep discovered by Medicare contractors.

In May 2009, Highmark Medical Services announced a prepayment review for sleep testing performed in New Jersey. CMS had found that approximately 50.5% of the New Jersey sleep test sample was billed incorrectly.

A month later, Highmark extended the review to Medicare sleep tests billed in Maryland. The Maryland invoices showed a 55% error rate.

A "prepayment" review is one tool CMS has to identify and force corrections of chronic billing errors. Prepayment review means that Medicare will hold payment of a subject claim pending a review that all Medicare coverage conditions are, in fact, in hand and satisfied.

Late last year, National Government Services, the Jurisdiction B Durable Medical Equipment (DME) Medicare Administrative Contractor, announced that it will be initiating a widespread prepayment medical review of claims for Medicare PAP devices to be dispensed in its area.

According to the Congressional testimony of Acting CMS Chief Financial Officer Deborah Taylor last April, CMS is focusing on "stop-gap" efforts to detect Medicare fraud.

"The stop-gap program increases pre-payment reviews of medical equipment suppliers and will also single out the highest-billed claims—continuous positive airway pressure (CPAP) devices, oxygen equipment, glucose monitors and test strips, and power wheelchairs," Taylor said in prepared remarks. She identified these items as the most lucrative items for suppliers and, thus, at the greatest risk of fraud.

These prepayment reviews reflect CMS' view that a good number of sleep test providers and DME suppliers are billing tests and CPAP incorrectly. The errors may be due to innocent processing errors or intentional avoidance of the complex documentation required to bill the service. CMS review could expand to other areas of the country depending on the results obtained in these initial reviews.

Although the extent and contours of sleep testing and therapy delivery are in flux, opportunities abound for those who can creatively assemble the new and evolving technologies in sleep. Industry participants should stay attuned to more changes as this decade unfolds.

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