The Sleepy Patient and the Exhausted Biller
A Bad Combination

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Disclaimer

This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion.
History of “Sleep Disorders”

• Obstructive sleep apnea “discovered” in 1965
• Conditioned insomnia was recognized in 1979
• Sleep onset insomnia such as delayed sleep phase syndrome, characterized in 1981
• Food allergy insomnia described in 1984

History of “Sleep Disorders”

• 1961 - Association for the Psychophysiological Study of Sleep (APSS)
  – First formally organized sleep medicine group in United States
  – Clinical sleep researchers
• 1970 - Stanford University Sleep Research Center
  – Predecessor of national clinical sleep disorders centers for the diagnosis and treatment of patients.
  – Founded by William Dement
History of “Sleep Disorders”

• 1976 - Association of Sleep Disorders Centers (ASDC)
  – Established a nationally recognized accreditation process for sleep disorders centers

• 1978 – Sleep – medical journal created
  – Articles devoted entire to sleep research

• 1989  Principles and Practice of Sleep Disorders Medicine
  – First comprehensive textbook
  – Edited by Meir Kryger, William Dement, and Thomas Roth

What is Apnea?

• Apnea is defined as a cessation of airflow for at least 10 seconds.

• Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation.

• Medicare Policy
What Does Medicare Cover?

- “Medical conditions for which testing is covered”
  - Narcolepsy
  - Sleep Apnea
  - Impotence
  - Parasomnia
    - Sleepwalking
    - Sleep terrors
    - REM sleep behavior disorders
  - “Polysomnography for Chronic Insomnia is not covered”

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Epworth Sleepiness Scale

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance Of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. a theater or a meeting)</td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td></td>
</tr>
</tbody>
</table>
Epworth Sleepiness Scale

• The score obtained by adding the numbers leads to a total:
  – 0 - 9 - average score, normal population
  – 10 - 24 - sleep specialist advice recommended

• Other Scales
  – 0 - 8  Normal sleep function;
  8 - 10 Mild daytime sleepiness;
  11- 15 Moderate daytime sleepiness;
  16- 20 Severe daytime sleepiness;
  21- 24 Excessive daytime sleepiness.

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Epworth Sleepiness Scale

• Many insurances are using this scale in determining “medical necessity”
  • Polysomnograms
  • In borderline polysomnogram results for CPAP

• Use this form as part of your pre-study evaluation
  • Cannot coach patient
  • Explain importance of honesty
POLYSOMNOGRAPHY
(sleep study)

• “A sleep test involving the continuous, simultaneous recording of physiological parameters for at least 6 hours that is performed in a sleep laboratory and attended by a technologist or qualified health care professional. “
  » CPT 2012

WHAT HAPPENS?

• Testing is done during sleep with various leads recording and compiling data which is stored in a computer.
• The testing is done with technician oversight.
SLEEP TRACING

WHAT HAPPENS?

• 12-14 leads monitoring for 6-8 hours
  – EEG
  – Eye Movement
  – Submental electromyogram (EMG)
  – ECG
  – Air flow
  – Ventilation and respiratory effort
  – Oximetry
  – Extremity muscle activity
Additional Areas of PSG Monitoring

- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions
- Penile tumescence

CPT CODES

- “95810 – Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

- 95811 – Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist.”
  - CPT-2012
Types of Sleep Tests  Studies

• **Type I** –
  • Attended studies (sleep studies that are performed with the oversight of a sleep technologist) with full sleep staging (sleep staging monitors the transition through the sleep stages, traditionally with the use of EEG electrodes that monitor the brain).

• **Type II** –
  • Home sleep test (HST) with Type II portable monitor, unattended (sleep studies that are performed without the oversight of a sleep technologist), with a minimum of 7 channels.

Types of Sleep Tests  Studies

• **Type III** –
  • Home sleep test (HST) with Type III portable monitor, unattended with a minimum of 4 channels.

• **Type IV** –
  • Home sleep test (HST) with Type IV portable monitor, unattended; minimum of 3 channels.
CPT Codes

• “95806 - Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory airflow and respiratory effort (eg thoracoabdominal movement) or peripheral arterial tone”
  
  • CPT 2012

New in CPT 2011

• “Sleep study, unattended, simultaneous recording;
  
    # 95800 - heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time
    # 95801 - Minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone) “
  
    CPT 2012
Evolution of Home Sleep Study Codes

<table>
<thead>
<tr>
<th>Unattended Study Type</th>
<th>HVPCS Code</th>
<th>CPT 2010</th>
<th>CPT 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type II – Minimum 7 channels</td>
<td>G0398</td>
<td>95806</td>
<td>95806</td>
</tr>
<tr>
<td>Type III - Minimum 4 channels</td>
<td>G0399</td>
<td>0203T</td>
<td>95800</td>
</tr>
<tr>
<td>Type IV – Continuous single or dual bioparameters</td>
<td>G0400</td>
<td>0204T</td>
<td>95801</td>
</tr>
</tbody>
</table>

Home Sleep Studies
The Billing Quandary

- Medicare coverage is based on Regional Carrier’s decision
  - Which code(s) to bill?
- Other insurances need to be verified for coverage
  - Which code(s) to bill?
### Home Sleep Studies

#### The Billing Quandary

<table>
<thead>
<tr>
<th>Billing for Study</th>
<th>Billing for Physician Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• G0398 – Type II Study</td>
<td>• 95806 – Type II Study</td>
</tr>
<tr>
<td>• G0399 – Type III Study</td>
<td>• 95800 – Type III Study</td>
</tr>
<tr>
<td>• G0400 - Type IV Study</td>
<td>• 95801 – Type IV Study</td>
</tr>
</tbody>
</table>

Perhaps

G0400 and 95801-26

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### MSLT

- “95805 - Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of psychological measurements of sleep during multiple trials to assess sleepiness”

  » CPT 2012
Sleep Medicine Testing
CPT Guidelines 2012

• Attended – a technologist of qualified health care professional is physically present (i.e. Sufficient proximity such that the qualified health care professional can physically respond to other appropriate needs or to technical problems at the bedside) throughout the recording session.

Sleep Medicine Testing
CPT Guidelines 2012

• Remote – the site of service is distant from the monitoring center. Neither a technologist nor a qualified health professional is physically present at the testing area.
Sleep Medicine Testing  
CPT Guidelines 2012

• Unattended – a technologist or qualified health care professional is not physically present with the patient during their recording session.

Be Cautious

• The ------ Sleep System allows the user to perform a complete Type I, 32 Lead, Attended sleep diagnostic test and manual pressure device titration while the patient remains in the comfort of their normal pristine sleep environment. This is not a "mobile" or "Home" sleep test but rather the "Gold Standard" of testing using the latest technology and FDA approved Sleep Diagnostic equipment.
Follow Up Studies

• Should not be “routinely” scheduled
• Intake order should indicate reason for study
• Documentation in sleep record of why study is being done
• Must be “medically necessarily”

Follow-up Study - WPS Medicare

• “Indicated for the following:
  – To evaluate the response to treatment (CPAP, oral appliances or surgical intervention);
  – After substantial weight loss has occurred in patients on CPAP for treatment of sleep-related breathing disorders to ascertain whether CPAP is still needed at the previously titrated pressure;
  – After substantial weight gain has occurred in patients previously treated with CPAP successfully, who are symptomatic again despite continued use of CPAP, to ascertain whether pressure adjustments are needed; or
  – When clinical response is insufficient or when symptoms return despite a good initial response to treatment with CPAP.”
Medicare CPAP Coverage
Pre-2009

- Coverage of CPAP in separate decisions
  - CMS limited coverage of CPAP
    - Only OSA diagnosed with polysomnography (PSG).

Medicare CR6534
CPAP - 2009

- Coverage expanded to OSA diagnosed with several types of HST. However, CMS has not, at a national level, specifically addressed coverage of the tests themselves.
- In other words, CPAP is nationally covered for beneficiaries with OSA if diagnosed with these specific tests; yet, coverage of the specific tests has previously been left to local contractor discretion.
Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)

Medicare National Coverage Determinations Manual Chapter 1, Part 4

240.4 - Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA)

- An initial 12-week period of CPAP is covered in adult patients with OSA if either of the following criterion using the AHI or RDI are met:
  - a. AHI or RDI greater than or equal to 15 events per hour, or
  - b. AHI or RDI greater than or equal to 5 events and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.
CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.
CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY: cont’d

For PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

– Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and

– Objective evidence of adherence to use of the PAP device reviewed by the treating physician.

Noridian Medicare Policy - (L171)

CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY: cont’d

Adherence to therapy is defined as use of PAP ≥ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

If the above criteria are not met, continued coverage of a PAP device and related accessories will be denied as not reasonable and necessary.

If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the patient is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.
CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:  *cont’d*

• Beneficiaries who fail the initial 12 week trial are eligible to re-qualify for a PAP device but must have both:
  – Face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and
  – Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study.

• If an E0601 device is tried and found ineffective during the initial facility-based titration or home trial,
  – substitution of an E0470 does not change the length of the trial unless there is less than 30 days remaining in the trial period.

• If more than 30 days remain in the trial period,
  – the clinical re-evaluation would still occur between the 31st and 91st day following the initiation of an E0601 and
  – objective documentation of adherence on the E0470 would need to occur prior to the 91st day following initiation of the E0601.

• If less than 30 days remain in the trial period,
  – the clinical re-evaluation and objective documentation of adherence must occur before the 120th day following the initiation of the E0601.
Medicare National Coverage

• Both issues addressed prior to changing from a CPAP to a bilevel:
  – A. Appropriate interface properly fit and beneficiary using it without difficulty; and
  – B. Current pressure setting of E0601 prevents beneficiary from tolerating therapy, and lower pressure settings of E0601 were tried but failed to:
    • 1. Adequately control symptoms of OSA; or
    • 2. Improve sleep quality; or
    • 3. Reduce the AHI/RDI to acceptable levels.

WPS Medicare Policy

• The physician performing the service must meet one of the following:
  – The physician is a diplomate of the American Board of Sleep Medicine (ABSM), Pulmonologist, Neurologist or
  – Has a Sleep Certification issued by one of the following Boards:
    • American Board of Internal Medicine (ABIM), American Board of Family Medicine (ABFM), the American Board of Pediatrics (ABP), the American Board of Psychiatry and Neurology (ABPN), and the American Board of Otolaryngology (ABOto) or
    • The physician is an active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO))

Eff: 12-10-10
Trailblazers Medicare - L28640 L28640

• The physician performing the service must meet one of the following:
  – The physician is a diplomate of the American Board of Sleep Medicine (ABSM).
  – The physician is a diplomate in sleep medicine by a member board of the American Board of Medical Specialties (ABMS).
  – The physician is an active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)).

Trailblazers Medicare - L28640 L28640

• A home sleep test is covered only when it is performed in conjunction with a comprehensive sleep evaluation and in patients with a high pretest probability of moderate to severe obstructive sleep apnea.
• Home sleep testing is not covered for persons with comorbidities (moderate to severe pulmonary disease, neuromuscular disease or congestive heart failure), other sleep disorders (central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders or narcolepsy) or for screening asymptomatic persons.
WPS Medicare Policy

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Eff: 12-10-10

WPS Medicare Policy - L31082

• The patient who undergoes a HST must receive, prior to the test, adequate instruction on how to properly apply a portable sleep monitoring device.
  – This instruction must be provided by the provider conducting the HST.

• Documentation must show that the home sleep test was accomplished with a Medicare-approved device (e.g., description of channels monitored or clear indications of same included in the test report) and was performed by a physician meeting the training requirements listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section.
WPS Medicare Policy

• Home Sleep studies are only covered for the diagnosis of Obstructive Sleep Apnea.
• They are not covered for any other sleep disorders (central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders or narcolepsy) or for screening asymptomatic persons

Eff: 12-10-10

MLN Matters Number: MM6048 Revised

• NOTE:
  – In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary’s treating physician are not considered reasonable and necessary.
  – Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.
WPS Medicare Policy

- Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered because it is not reasonable and necessary under §1862(a)(1)(A) of the Act.

- 42 CFR Section 410.32
  - Only treating physician can order diagnostic tests
  - Or other treating practitioner who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

Eff 12-10-10

2012 CPT – New Guidelines

- All sleep services (95800-95811) include recording, interpretation and report.

- Report with modifier 52 if less than 6 hours of recording for 95800, 95801 and 95806-95811 and if less than four nap opportunities.
PAP NAPS

- DO not bill with PSG code with reduced service modifier
  - i.e. 95810 - 52
- There is no specific code for this service
- 95999 – Unlisted neurological or neuromuscular diagnostic procedure

Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements - Medlearn Transcript

We will begin our discussion with the following four common documentation errors for PAP Devices:

(1) No documentation of the treating physician’s initial face-to-face clinical evaluation conducted before the sleep study to assess the beneficiary for obstructive sleep apnea, or O-S-A.

(2) No documentation of the Medicare-covered sleep study supports medical necessity.

Audio Date: 10/07/2011
ICN: 906984

Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements - Medlearn Transcript

• Cont’d

(3) No documentation of the treating physician’s signed and dated order describes the items dispensed, and

(4) No documentation of the treating physician’s face-to-face re-evaluation within the first three (3) months (but no sooner than the 31st day) of initiating therapy. This shows improved symptoms of O-S-A and adherence to PAP therapy.

Audio Date: 10/07/2011
ICN: 906984
327.0x - Organic Disorders of Initiating and Maintaining Sleep [organic insomnia]

- 327.00 - Organic insomnia, unspecified
- 327.01 - Insomnia due to medical condition classified elsewhere
  - *Code first underlying condition*
- 327.02 - Insomnia due to mental disorder
  - *Code first underlying condition*
- 327.09 - Other organic insomnia

327.1x - Organic Disorder of Excessive Somnolence (Organic hypersomnia)

- 327.10 - Organic hypersomnia, unspecified
- 327.11 - Idiopathic hypersomnia with long sleep time
- 327.12 - Idiopathic hypersomnia without long sleep time
- 317.13 - Recurrent hypersomnia
  - Klein-Levin syndrome
  - Menstrual related hypersomnia
327.1x - Organic Disorder of Excessive Somnolence (Organic Hypersomnia)

- 327.14- Hypersomnia due to medical condition classified elsewhere
  - *Code first underlying condition*
- 327.15- Hypersomnia due to mental disorder
  - *Code first mental disorder*
- 327.19- Other organic hypersomnia

327.2x - Organic Sleep Apnea

- This category excludes:
  - Cheyne-Stokes breathing (786.04)
  - Hypersomnia with sleep apnea NOS (780.53)
  - Insomnia with sleep apnea NOS (780.51)
  - Sleep apnea in newborn (770.81-770.82)
  - Sleep apnea NOS (780.57)
327.2x - Organic Sleep Apnea

• 327.20 Organic sleep apnea, unspecified
• 327.21 Primary central sleep apnea
• 327.22 High altitude periodic breathing
• 327.23 Obstructive sleep apnea (adult)
  (pediatric)
• 327.24 Idiopathic sleep related nonobstructive
  alveolar hypoventilation
  • Sleep related hypoxia

327.2x - Organic Sleep Apnea
(cont’d)

• 327.25 Congenital central alveolar hypoventilation
  syndrome
• 327.26 Sleep related hypoventilation/ hypoxemia in
  conditions classifiable elsewhere
  – Code first underlying condition
• 327.27 Central sleep apnea in conditions classified
  elsewhere
  – Code first underlying condition
• 327.29 Other organic sleep apnea
327.3x - Circadian Rhythm Sleep Disorder

- Organic disorder of sleep wake cycle
- Organic disorder of sleep wake schedule

**Excludes:**
- Alcohol induced circadian rhythm sleep disorder (291.82)
- Circadian rhythm sleep disorder of nonorganic origin (307.45)
- Disruption of 24 hour sleep wake cycle NOS (780.55)
- Drug induced circadian rhythm sleep disorder (292.85)
327.3x - Circadian Rhythm Sleep Disorder

- 327.35 Circadian rhythm sleep disorder, jet lag type
- 327.36 Circadian rhythm sleep disorder, shift work type
- 327.37 Circadian rhythm sleep disorder in conditions classified elsewhere
  - *Code first underlying condition*
- 327.39 Other circadian rhythm sleep disorder

327.4x - Organic Parasomnia

- This subcategory excludes:
  - alcohol induced parasomnia (291.82)
  - drug induced parasomnia (292.85)
  - parasomnia not due to a known physiological condition (307.47)
327.4x - Organic Parasomnia

- 327.40 Organic parasomnia, unspecified
- 327.41 Confusional arousals
- 327.42 REM sleep behavior disorder
- 327.43 Recurrent isolated sleep paralysis
- 327.44 Parasomnia in conditions classified elsewhere
  - Code first underlying condition
- 327.49 Other organic parasomnia

327.5x - Organic Sleep Related Movement Disorders

- This category excludes the following:
  - restless leg syndrome (333.94)
  - sleep related movement disorder NOS (780.58)
327.5x - Organic Sleep Related Movement Disorders

- 327.51 Periodic limb movement disorder
  Periodic limb movement sleep disorder
- 327.52 Sleep related leg cramps
- 327.53 Sleep related bruxism
- 327.59 Other organic sleep related movement disorders
- 327.8 Other organic sleep disorders

333.9x - Other and Unspecified Extrapyramidal Diseases and Abnormal Movement Disorders

- 333.94 - Restless legs syndrome (RLS)
780.5x Sleep Disturbances

- 780.50 Sleep disturbance, unspecified
- 780.51 Insomnia with sleep apnea, unspecified
- 780.52 Insomnia, unspecified
- 780.53 Hypersomnia with sleep apnea, unspecified
- 780.54 Hypersomnia, unspecified
- 780.55 Disruptions of 24 hour sleep wake cycle unspecified
- 780.56 Dysfunctions associated with sleep stages or arousal from sleep
- 780.57 Other and unspecified sleep apnea, unspecified
- 780.58 Sleep related movement disorder, unspecified
- 780.59 Other

278 Overweight, Obesity and Other Hyperalimentation

278.0 Overweight and obesity
   - Excludes: adiposogenital dystrophy (253.8) obesity of endocrine origin NOS (259.9)
   - Use additional code to identify Body Mass Index (BMI) if known (V85.0-V85.54)

- 278.00 Obesity, unspecified
  - Obesity NOS
- 278.01 Morbid obesity
  - Severe obesity
- 278.02 Overweight
278 Overweight, Obesity and Other Hyperalimentation

• 278.03 Obesity hypoventilation syndrome
  – Pickwickian Syndrome

V85.xx - Body Mass Index (BMI)

_BMI adult codes are for use for persons over 20 years old_

• V85.0 Body Mass Index less than 19, adult
• V85.1 Body Mass Index between 19-24, adult
• V85.2 Body Mass Index between 25-29, adult
• V85.3 Body Mass Index between 30-39, adult
• V85.4 Body Mass Index 40 and over, adult
V85.xx Body Mass Index (BMI)

V85.4 Body Mass Index 40 and over, adult
(no longer valid code)
• V85.41 Body Mass Index 40.0-44.9, adult
• V85.42 Body Mass Index 45.0-49.9, adult
• V85.43 Body Mass Index 50.0-59.9, adult
• V85.44 Body Mass Index 60.0-69.9, adult
• V85.45 Body Mass Index 70 and over, adult

V85xx - Body Mass Index

• V85.5 Body Mass Index, pediatric

• Note: BMI pediatric codes are for use for persons age 2-20 years old. These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC)
Documentation of BMI

• Code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis).

• However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient’s provider.

• If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.
OIG Work Plan 2011

- Appropriateness of Medicare Payments for Polysomnography
- Medicare Payments for Sleep Testing
- Geographic Areas With a High Density of Independent Diagnostic Testing Facilities
- Independent Diagnostic Testing Facilities’ Compliance With Medicare Standards

OIG Work Plan 2012

- Sleep Disorder Clinics: Medicare Payments for Sleep Testing
- Sleep Testing: Appropriateness of Medicare Payments for Polysomnography
QUESTIONS???

Thank you!

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