

Comment #58:

Submitter: David A. Lewis, M.D.

Organization: Pulmonary, Critical Care & Sleep Medicine  
Group Health Permanente

Date: Thu, May 6, 2004 8:14 PM

Comment:

I am writing to give my full support for the request by Timothy Davidson, MD to modify the current national guidelines for CPAP coverage to include the use of portable multi-channel home sleep testing devices as an alternative to facility-based polysomnography in the evaluation of OSA. I am the Service Line Chief for Group Health Permanente Pulmonary, Critical Care, & Sleep Medicine based in Washington State and previously directed the Sleep Laboratory at Harbor-UCLA Medical Center (1993-99). I am a Diplomate of the American Board of Sleep Medicine in addition to the American Board of Internal Medicine (Internal Medicine, Pulmonary Diseases, and Critical Care Medicine.) I do not have financial ties to any companies making equipment used for portable testing or for the treatment of sleep-related breathing disorders, nor any financial gain to be had by the use of either portable sleep monitors or facility-based polysomnography.

I have been involved in portable testing for the diagnosis of obstructive sleep apnea syndrome since my early fellowship training at Harbor-UCLA. As director of the Harbor-UCLA Sleep Laboratory, I continued to use portable testing to help keep up with the demand for sleep testing for this important disease in excess of the capacity of my polysomnography laboratory. As co-director of the Group Health Cooperative Sleep Laboratory since 1999, I continue to find portable testing to be acceptable for the diagnosis of obstructive sleep apnea syndrome in the majority of patients we see. There are subtle presentations of sleep-disordered breathing that may be missed by portable testing, though false positive studies in patients suspected to have sleep apnea are very rare. We prefer to utilize our comprehensive polysomnography laboratory to ensure that negative home tests are, indeed, negative in patients with suspected sleep apnea; for the diagnosis of non-apnea sleep disorders (that do require EEG/EMG information); and for the titration of CPAP and BiPAP in patients diagnosed with OSA who do not find clinical improvement with home- or auto-titration of CPAP.

The Group Health sleep program based on portable testing has been operative since 1994 and has been highly successful in improving access to testing for patients with suspected sleep-disordered breathing. Patients are often seen for initial consultation and started on CPAP within one week (and sometimes within 24 hours), greatly reducing the wait time for treatment initiation compared to national and local averages using facility-based polysomnography testing. Our sleep medicine providers and patients are both very happy with the improved access. Unfortunately, our Medicare and Medicaid patients are required to wait for 1-2 months for a facility-based polysomnography study (a much more expensive and much less convenient test) before they can start therapy. As a healthcare professional, I am greatly concerned that this delay in diagnosis and treatment increases the risks of serious complications of this very common disease (traffic accidents, declining work performance, development of hypertension, exacerbation of heart failure, etc.)

I strongly support the use of portable monitors to greatly improve access to testing for the diagnosis of obstructive sleep apnea syndrome and sincerely hope that CMS will modify their requirements for CPAP coverage to include portable testing as an alternative to facility based PSG. Obstructive sleep apnea is a very common and potentially deadly disease that needs early treatment initiation to reduce complications and improve patient quality of life.

Comment #59:

Submitter: Richard L. Goode, M.D.

Organization: Stanford University School of Medicine

Date: Thu, May 6, 2004 7:50 PM

Comment:

I am an academic otolaryngologist at Stanford with a significant portion of my practice in the field of sleep disordered breathing. I strongly feel that Medicare and Medicaid should reimburse for multi-channel home sleep studies. There are several reasons for this. First, there is a great deal of data to support that these studies, when properly done with several of the portable devices now available, correlate well with monitored in hospital studies. The absence of an EEG channel is not a reason to deny reimbursement. Second, a large number of patients do not need all the information that the monitored study provides--some do. In these cases a second study may be required but more often these patients can be screened out. A 325 pound male with heart disease and suspected sleep apnea needs a monitored study. Third, cost. The home tests are much cheaper. Fourth, delay. It takes weeks at Stanford to obtain an overnight monitored study. While they will do home studies, they know that they will not be reimbursed in Medicare/Medicaid patients for so they will schedule the in house study. Fifth, interpretation. Modern units provide computer generated, accurate data that can be classified by a variety of proven algorithms so that the severity of the OSA can be measured. Sixth, access. Independent of cost, the inconvenience of such a study turns off many patients. It is well known that there is a large number of undiagnosed OSA patients and the use of convenient testing would make it much easier to obtain patient compliance. Seventh, repeat testing. Some home units allow for testing on more than one night. This is helpful r.e. verifying borderline cases, role of drugs, alcohol, etc. as well as evaluation of dental devices, nasal opening devices, etc.

I am concerned that those physicians with a vested interest in overnight sleep studies have been able to convince Medicare/Medicaid that there is no role for home multi-channel sleep studies. The baby was thrown out with the bathwater. We need both and both should be reimbursed; the home studies should be reimbursed at a lower rate than the hospital studies, of course. It is time to correct this inequity and I do not feel there is evidence that standards will decrease or that the use of testing will be abused. It will obviously increase the amount of tests, as it should since the incidence is high and those with undiagnosed disease are at risk for major complications.