**Recommendations for Implementation of Portable Monitoring for**

**Obstructive Sleep Apnea**

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The American College of Chest Physicians is a professional society of 17,000 pulmonary, critical care and sleep medicine physicians, cardiothoracic surgeons, cardiologists and allied health professionals whose goal is to support education and patient focused care in our areas of expertise, including sleep medicine. The ACCP's Sleep NetWork (with 3,000 members) and Sleep Institute are driving forces in sleep medicine with an interest in fostering excellent patient care and rigorous standards of excellence in the diagnosis and provision of health care to those with sleep disorders. We appreciate the opportunity to further comment on the CMS proposed changes for the National Coverage Determination of Continuous Positive Airway Pressure (CPAP). We are committed to working with patients, colleagues and payers to facilitate implementation of home sleep testing so that patient care is enhanced. We have comments in several areas pertinent to the NCD.

Physician care and responsibility. We believe that patients with suspected or proven obstructive sleep apnea will potentially be cared for by several different practitioners, and the responsibilities and credentials of these individuals should be defined. The ordering physician should examine the patient and establish medical necessity for testing. This clinician has the choice as to which type of test is used (home or laboratory based), based on the patient's history and clinical status. Similarly, this clinician may select a device for home sleep testing that uses alternative technology not requiring electroencephalograpy. Home sleep testing should generally be reserved for those patients with strongly suspected straight-forward obstructive sleep apnea with an expected benefit from CPAP treatment. This physician should recognize that more complex patients, such as those with morbidities including congestive heart failure, chronic obstructive pulmonary disease and atrial fibrillation, are not good candidates for home testing. The physician interpreting home sleep apnea tests should be trained and have experience in the performance and interpretation of diagnostic polysomnography. Physicians ordering and interpreting portable sleep apnea tests should be affiliated with, and have access to, a facility-based sleep laboratory and specialists board certified in Sleep Medicine or Pulmonary Medicine, so that patients have access to the best study for their clinical needs. The physician should be able to continue the evaluation and treatment for patients for whom portable sleep apnea testing does not provide a definitive diagnosis and satisfactory clinical outcome and for patients with other sleep problems besides sleep apnea. In all cases, review of the raw data should form the basis for deciding the adequate quality and final interpretation of the study. The treating clinician (who prescribes CPAP) or a designated caregiver should make a judgment along with the patient about effectiveness at 12 weeks.

Measurement and documentation of benefit. Measures of CPAP treatment benefit could include any of the following: objectively measured hours of use, objectively measured nightly use, declaration by practitioner or by patient of benefit, improvements of blood pressure control, diabetes control, Functional Outcomes of Sleep Questionnaire (FOSQ), Epworth Sleepiness Scale (ESS), or other measure of general healthcare and performance benefit. A declared plan of continued CPAP use is also a statement of perceived benefit. The effectiveness of CPAP should be documented in the medical record.

CPT and HCPCS. The ACCP Sleep Institute recognizes that the HCPC codes are helpful for classifying types of portable or home monitors. However, there is potential for overlap and confusion. The newly proposed G0399 code, in particular, may pose an unnecessary conflict with the nearly identical existing CPT code, 95806 for Type 3 home testing. One or the other should be altered or eliminated.

Testing and Treatment. While the ACCP supports the decision that ... portable monitoring is suitable, **but not optimal**, for prescribing CPAP, we **also** believe that such testing is not adequate for making decisions about surgical treatment of sleep apnea. Irreversible therapy such as surgical interventions should be based upon laboratory based formal polysomnography.

Definitive diagnosis and follow-up care. The ACCP notes that portable testing can be used to establish a diagnosis of sleep apnea, but not to rule it out. Further, the technical failure rate with home testing can be substantial. Ultimately, if a home sleep test does not provide a definitive diagnosis, there should be no obstacle to in-lab testing. Decisions to repeat a study at home or in the lab should not be regarded a duplicative testing if the physician evaluating the patient feels the clinical situation warrants this. The reason for repeat testing should be fully documented in the medical record at or prior to the laboratory based test.

Regional Variation. An acknowledged benefit of home testing is its applicability and availability in areas of scarce resources. It can be expected that practice patterns will vary depending on the available resources and needs of the patient. The ACCP supports adaptation of regional implementation plans taking into account the unique local needs and resources.