Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Sleep Easy With These 4 Sleep Apnea Coding Steps

Hint: Obtain pre-authorization before the lights go out

If your practice doesn't manage carrier-specific guidelines when trying to diagnose and treat a patient who may have sleep apnea, you could wake up to pre-authorization and claims denials.

There is no National Coverage Determination (NCD) for sleep disorder testing, so you must check your carrier's Local Coverage Determination (LCD) or other billing guidelines to know the exact coverage requirements.

Follow these four steps to maximize your success with sleep apnea testing claims:

1. Determine sleep apnea type. Sleep apnea falls under ICD-9 series 780.5x (General symptoms; sleep disturbances). The diagnosis is appropriate when a patient stops breathing for ten or more seconds during sleep, and occurs in two forms:

1. **Obstructive sleep apnea** (OSA), is when a person's airway becomes closed off during sleep, specifically when the person inhales. The condition most commonly occurs in patients with obesity, though other problems, such as big tonsils, can cause the problem. Report **ICD9 780.53** (Hypersomnia with sleep apnea) for obstructive sleep apnea.

2. **Central sleep apnea** occurs when the brain doesn't send a message to the body to breathe. The condition usually occurs in older patients and is the result of neurological problems (such as a stroke or a tumor) or congestive heart failure (CHF). Report 780.51 (Insomnia with sleep apnea) for central sleep apnea.

   You can only code symptoms of sleep apnea for the patient's initial visit because you can't report a definitive sleep apnea diagnosis code unless the results of the patient's polysomnography are positive. Diagnosis codes you might report before the physician has made a definitive apnea diagnosis are snoring (786.09 - Dysapnea and respiratory abnormalities; other) and daytime fatigue (780.79 - Other malaise and fatigue). You may also report co-morbidities such as 278.01(Obesity and other hyperalimentation; morbid obesity), 250.xx (Diabetes mellitus), and 428.0 (Heart failure; congestive heart failure, unspecified).

   Avoid this V code: V69.4 (Problems related to lifestyle; lack of adequate sleep) is more fitting for a patient who stays up until 4 a.m. working and gets up at 7 a.m. for school, rather than someone who is not sleeping because of a medical condition.

   Don't be tempted to report codes from series 307.4x (Special symptoms or syndromes, not elsewhere classified; specific disorders of sleep of nonorganic origin) such as 307.46 (...sleep arousal disorder) in suspected apnea cases; those codes are for insomnia diagnoses and are mental disorder codes.

   Note: Be aware 780.51 is also the diagnosis code for obesity hypoventilation syndrome (OHS), a related disorder that may or may not occur along with OSA. OHS, also know as Pickwickian syndrome, occurs when a patient is so obese he is unable to take in a sufficient amount of oxygen during sleep, resulting in high carbon dioxide levels in the blood.

2. Check for carrier-required symptoms. "The criteria for sleep apnea coverage is carrier-driven and changes by region," notes **Jill M. Young, CPC**, of **Young Medical Consulting, LLC** in East Lansing, MI, who recently presented "Not All Snorers Have Apnea: Understanding the Codes of Sleep Disorders" at the 2005 AAPC Annual Conference.

For example, **Blue Cross Blue Shield North Carolina** requires the patient must exhibit snoring along with one of the following: witnessed apnea, unexplained hypertension or arrhythmia, or daytime sleepiness. Medicare carrier **HGSAdminstrators** of Pennsylvania, however, requires documentation of witnessed apenic episodes, daytime sleepiness and severe snoring in order to perform a sleep study for suspected sleep apnea.

If the patient exhibits the symptoms the carrier requires, the physician may then order a polysomnography to confirm that the patient actually has sleep apnea. Polysomnography is a diagnostic sleep test that monitors a number of factors, including a patient's breathing, heart rate, EKG, blood oxygen and limb muscle activity.

Remember: Get pre-authorization from your carrier to perform the sleep test and follow its guidelines. Also check to make sure the carrier lists the sleep-testing center as an approved laboratory facility. Medicare coverage, for example, requires that a patient undergo supervised polysomnography testing in an approved laboratory facility in order to document the apnea episodes. Medicare does not cover at-home sleep tests.

3. Advance to 95811 after apenic episodes. Sleep testing for sleep apnea generally involves only two codes - 95810 and 95811. First, the technician performs a polysomnography, which you code using 95810 (Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist). This service determines if the patient indeed suffers from sleep apnea. Under HGSA guidelines, a patient must experience five episodes of apnea during at least six hours of sleep.

If the patient meets the lab's criteria for sleep apnea, the lab technician then initiates continuous positive airway pressure (CPAP) on the patient and adjusts or 'titrates' the pressure until he attains the pressure that causes the patient's apenic episodes to stop. You would code this second procedure with 95811 (Sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist).

When coding polysomnography, remember that the National Correct Coding Initiative (NCCI) bundles 95810 and 95811 if you perform both tests in the same session, says Young. "The first one is the test, and the second one is the test plus initiation of CPAP," she explains. However, you may bill for both 95810 and 95811 if you perform them in separate sessions.

Example #1: A 45-year-old obese male with diabetes who shows symptoms of sleep apnea goes to a sleep lab for a polysomnography. By 11 p.m., he suffers 30 apenic episodes and qualifies as having sleep apnea under his insurance carrier's guidelines. The tech initiates CPAP and finds the pressure that causes the apenic episodes to stop.

You code: 95811 only, because the patient undergoes CPAP in the same session as the polysomnography. Billing both 95810 and 95811 would be inappropriate because you would be ignoring the mutually exclusive NCCI edit.

Example #2: A 66-year-old female Medicare patient undergoes 95810; however, she takes six hours to meet Medicare's criteria for sleep apnea, and by then it is too late to initiate CPAP. The patient returns the next night and the tech administers CPAP.

You code: 95810 for the first night and 95811 for the second night. Both procedures are billable because they occurred in separate sessions.

Note: If the lab tech terminates CPAP with less than six hours of recording because the patient is intolerant, some carriers, such as **Cahaba** of Iowa and South Dakota, require that you append modifier -52 (Reduced services) to 95811.

4. Add modifiers if component billing: The other question you should ask when billing polysomnography is "What type of facility performed the test?" Depending on where a patient undergoes a polysomnography and who interprets the results, you may bill 95810 and 95811 either as global codes or as components using modifiers -TC (Technical component) and -26 (Professional component), says **Karen Dorval, CPC,** of the **Pneumos Clinic** in Bismarck, ND.

Example #1: The patient's pulmonologist, who is certified in interpreting sleep studies, sends the patient to the

hospital's sleep lab, which performs 95810 and 95811 in the same session. The pulmonologist bills 95811-26 for interpreting the test results, and the lab bills 95811-TC for performing the test.

Example # 2: A patient's primary physician sends the patient to an independent sleep lab (that has on-site doctors who interpret the test results) for a polysomnography. The lab performs 95810 and 95811 on the same night. The sleep lab reports 95811 because the facility does global billing and then pays its doctors the professional fee. The patient's primary physician bills nothing because he did not run the test or interpret the test results

Medicare guidelines state if the lab is physician-owned (i.e., a group of ten doctors certified in sleep testing), the facility may bill either global or component, depending on how the facility billing is set up, says Young.