Part B Insider (Multispecialty) Coding Alert

PULMONOLOGY: Ditch 780.x, Pick Up 327.x For Sleep Testing, Polysomnography

Old insomnia, apnea codes became 'unspecified' codes in October

You think you know all about how to code for sleep testing (95805-95807) and polysomnography (95808-95811), but everything changed last October. Are you up to speed yet?

No, the CPT codes for sleep studies didn't change, but the diagnosis codes did. You may be used to using the 780.x series of diagnosis codes for insomnia and sleep apnea, but you'll have to switch to the 21 new codes that took effect Oct. 1. These codes are much more detailed, which means you'll have to learn to give more specifics.

For example: In the past, you would have used 780.54 for ideopathic hyperinsomnia. But now, you'll have two codes to choose from: 327.11 (with long sleep time) and 327.12 (without long sleep time).

Similarly, you would have billed 780.51 for insomnia with sleep apnea. Now you must choose between 327.26 (Sleep related hypoventilation/hypoxemia in conditions classifiable elsewhere) and 327.27 (Central sleep apnea in conditions classified elsewhere).
The 780.5x series of codes will all become "unspecified" codes for insomnia with sleep apnea (780.51), insomnia (780.52), hypersomnia with sleep apnea (780.53), hypersomnia (780.54) and sleep apnea (780.57).

Good news: You should celebrate the fact that the new codes offer more specificity, says **Jill Young** with **Young Medical Consulting** in East Lansing, MI. They include new codes for primary central sleep apnea (327.21) and central sleep apnea in conditions classified elsewhere (327.27).

Now you just have to hope non-Medicare payors start accepting the codes soon, because many apnea patients are in their 30s or 40s. Some payors still believe that all diagnosis codes in the 300 series are mental health codes, but in fact "mental health stops at 319," says Young.

Beware: If you stick to the old codes, you could receive payment for now, because they still cover "unspecified" conditions. But as a coder, you're required to use the most specified code, says Young. Once the patient has undergone a sleep test, you ought to be able to code the exact type of apnea the patient suffers from.

Some physician offices have been slow to adopt the new codes. "It's just in a different section of the book than we normally use," says one coder with a pulmonology office. She sent the list of codes to the physicians in her practice, and so far none of them have gotten back to her about using them.

Watch for: Sometimes a physician will say "sleep study" when he means "polysomnography," notes Young. People often use those two terms interchangeably. But your practice could be losing money if your physician interprets a polysomnography and you bill for it using the sleep study codes (95805-95807).

The main difference between sleep studies and polysomnography is that polysomnography requires sleep staging. Also, you must specify how many parameters, such as respiration or muscle activity, the study examined. If the study examined three or fewer parameters, then you should submit 95808. For four or more, submit 95810, or 95811 if the patient was using a continuous positive airway pressure (CPAP) device.