



Sleep Educator Reimbursement Guide

Introduction

This Reimbursement Guide is geared towards sleep professionals working as clinical sleep educators, Certification in Clinical Sleep Health credential holders, or those who hope to develop a program in their sleep center but aren't sure how to bill for these services. Because these are new, evolving roles, there's a lack of clarity and consistency in the field about how to bill for activities such as PAP de-sensitizations, mask fittings, and smart card downloads. This guide aims to summarize some of the billing practices in the field today. We hope that as the field evolves, this will be regularly updated to reflect such developments.

Disclaimers

The following guide gives an overview of how various labs/clinics are using codes today. This should not be taken as advice about the appropriateness of any code for a specific institution or setting. Various payors/jurisdictions may have additional requirements for billing these codes, which could change at any time. Check with your contracted insurance carriers and/or your local Medicare contractor for any questions you may have about appropriateness of a specific code to your center.

Acronyms Used in this Guide

ACRONYM	FULL TERM	DESCRIPTION
CPT	Current Procedural Terminology	Billing codes for use in various medical, surgical, and diagnostic procedures.
CMS	Centers for Medicare and Medicaid Services	The United States government division that administers the Medicare and Medicaid programs and sets rules for payments.
E&M	Evaluation and Management	Billing codes which are typically used in the clinic or physician office setting.
HCPCS	Healthcare Common Procedure Coding System	
LCD	Local Coverage Determination	Medicare guidelines set at the regional level by a MAC.
MAC	Medicare Administrative Contractor	Medicare utilizes private contractor organizations to oversee regional implementation of its programs. MACs often cover multiple states and may set additional requirements for reimbursement.
NCD	National Coverage Determination	Medicare guidelines for reimbursement on most procedures at a national level. The NCD supersedes the LCD in cases where they may conflict.
OPPS	Outpatient Prospective Payment System	Medicare payment rates and copay rates for most outpatient hospital services.

Which Codes to Use?

The type of setting you are in and the presence of physicians will be the main drivers of the types of codes you should consider (as opposed to highest reimbursement rate). Each code or set of codes presented below is meant for a specific setting. Read through the code descriptions and requirements carefully as you determine the best option for your workplace.



NOTE that the last three of these codes involve phrases such as 'counseling' and 'coordinated care'. These services should be well defined in your center and be part of a standardized curriculum performed with each patient. There should be a discussion with the patient and/or family concerning one or more of the following:

- Diagnostic results, impressions and/or recommended studies
- Prognosis; risks and benefits of management/treatment options
- Instructions for management/treatment or follow-up
- Importance of compliance with chosen management options
- Risk reduction
- Patient and family education

Evaluation and Management Codes (E&M Codes)

These codes should generally be used only in a physician office/clinic setting. There are better codes for hospital based sleep labs. There should always be a physician or nurse practitioner present to bill the code. Patients are categorized as either 'new' or 'established'. You are most likely only going to work with established patients, because these are the ones who are likely having problems with their ongoing therapy. All of the codes presented here are for 'established' patients only. There are various levels of visit code depending on complexity/number of problems.

When you use these codes, you are technically working under the supervision of a physician for the day and must have a recognized credential. No specific credential is specified in the coding guidelines, as they apply to more than just sleep medicine. Potential credentials could include: RN, RPSGT, CCSH, and RRT. A physician doesn't always have to see the patient directly for some of these codes. Using a level one Evaluation and Management (E/M) code (e.g. 99211) for services not provided by a physician/healthcare provider is called "incident to services". This includes services by other professionals "under the same roof, at the same time" as the physician.

HERE'S A REAL-LIFE EXAMPLE: *During an office visit, a patient is found to have an elevated blood pressure and the physician asks the patient to return the next day to have the blood pressure rechecked by a nurse. The following day, a nurse checks the blood pressure while the physician is in the office seeing other patients. The physician reviews the blood pressure and signs off on it without seeing the patient: the physician must be in the same building when the nurse is checking the blood pressure. This is typically a minimal problem lasting at least five minutes. Of course, it is important to note that five minutes is not likely sufficient for CPAP patients.*



Specific E&M Codes

All of these codes and descriptions can be found on the [CMS website](#).

99211

OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, **THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL**. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, **5 MINUTES** ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.

99212

OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES **AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS**, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. TYPICALLY, **10 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY**.

99213

OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; **AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS**, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. TYPICALLY, **15 MINUTES** ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.

99214

OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF **MODERATE TO HIGH SEVERITY. TYPICALLY, 25 MINUTES** ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.

99215

OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. **USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. TYPICALLY, 40 MINUTES** ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.



Hospital Based Sleep Lab: Option #1

Perhaps the most commonly used code in this setting is 94660- "CPAP Initiation and Management." This code was originally used for bi-level therapy in the ICU. However, at its most recent CPT review, it was changed to include PAP acclimation as an outpatient. Medicare reimbursement rates vary by region but are approximately \$65. To bill this code, the patient must already have established care with a physician. This code should not be billed with any Evaluation and Management (E&M) codes. There remains some debate about whether this code may be used in a physician office space, but the most conservative option would be only to use it in a hospital-based sleep center.

One point of debate with this code is whether it requires 40 minutes of physician time (in addition to the technologist's time spent with the patient). Some centers have interpreted this code to cover the total combined time, but again to be conservative you should consider assuring a full 40 minutes with a physician. For this reason, most providers find it more appropriate to code for an E/M code based upon face-to-face time spent with the patient. Current reimbursements may also favor using the E&M code where possible (as a comparison, Medicare pays \$63 for 94660 and \$73 for a 15 minute E/M (99213).

Hospital Based Sleep Lab: Option #2

The HCPCS code G0463 concerns hospital outpatient clinic visits for the assessment and management of a patient for payment under the Outpatient Prospective Payment System (OPPS) for outpatient hospital clinic visits. This code should be used instead of CPT codes 99201-99205 and 99211-99215. The reason is that effective January 1, 2014; those CPT codes are no longer recognized for payment under the OPPS. The code cannot be used for services performed in a physician's office, the service must be provided in an actual sleep lab operating as such.

PAP Compliance Card Download and Interpretation

There are two possible codes to use for downloading of compliance data. These codes are not specific to CPAP management and therapy, and they can be billed if the physician is reviewing data but not meeting with the patient. These codes may have an increased relevance with mandatory auto-PAP at home since reviewing data from auto-titrating machines can take more time and consideration.

- **99090:** Analysis of clinical data stored in computers.
- **99091:** Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requires minimum 30 minutes.

The America Academy of Sleep Medicine (AASM) has issued a statement of caution on the use of 99091:

"There is no CPT that exactly describes the download and interpretation of smart card data. The service is best described by code 99091, which describes the collection and interpretation of physiologic data. The service is described to last a minimum of 30 minutes. Providers are encouraged to contact the private payers they work with to determine if 99091 is a payable code. However, for Medicare, code 99091 is considered a bundled service, which is to say that it is not separately billable and payment for the service is considered to be included in other services billed that day. For example, the download and interpretation of data from a smart card would be considered to be part of an evaluation and management service performed on that patient. The review of data could increase the complexity of the service and therefore the reimbursement for the interpretation of smart card data could be included in the evaluation and management reimbursement."

<http://www.aasmnet.org/codingfaq.aspx>



“PAP Nap”

Many centers run shorter duration PAP acclimatization studies. The typical PAP nap records a reduced number of channels (e.g. respiratory, pulse/oximeter, and flow) with the goal of the patient briefly falling asleep. We put this procedure name in quotation marks because the most commonly used code for this procedure (95807-52) is only vaguely applicable. There is no specific code that describes the typical PAP Nap. Generally, it is suggested not to bill this for government payors, whether federal or state. Again, the AASM provides prudent guidance:

“There are no codes in the CPT codebook that specifically describe the PAP-Nap service. Some physicians have reported receiving reimbursement for PAP-Naps coded as 95807-52 in their area. However, that code only approximately reflects the service that is being performed. The modifier 52 indicates reduced services (less than the complete 95807 service is being performed). Sleep centers interested in providing the PAP-Nap service should contact the insurers they work with for confirmation that this is considered a covered service. There are payers that have identified PAP-Nap in their policies as non-covered.”

<http://www.aasmnet.org/codingfaq.aspx>

Patient Education Codes

Another option for sleep educators and CCSH credential holders is to use generic patient education codes 98960-98962. These are the same codes often used by diabetes educators and asthma educators, but sleep could also qualify. It is not necessary to work under a

physician to use these codes, although for best practice, a physician should write an order for you to perform the service. It is important with these codes that you document 30 minutes or more of time, that you utilize a standardized curriculum for instruction, and that you be ‘qualified.’ Because these are generic codes, the qualification isn’t specified in the CPT description. It could mean being an RPSGT with a CSE certificate add-on, or a CCSH, or something else entirely. We would suggest trying these out with non-government payors until and unless an LCD or NCD specifies which qualifications are appropriate for Medicare patients.

98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with patient (could include caregiver/family) each 30 minutes; individual patient.
98961	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients.
98962	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients.

<https://www.diabeteseducator.org/practice/ask-the-reimbursement-expert/reimbursement-q-a>



Summary of All CPT Codes

CODE	SETTING	PHYSICIAN ROLE
99211	Clinic/Physician office	Must be in building
99212	Clinic/Physician office	Must be in building
99213	Clinic/Physician office	Must be in building
99214	Clinic/Physician office	Must be in building
99215	Clinic/Physician office	Must be in building
94660	Sleep Center	Debate – may require 40 minutes of physician time
G0463	Sleep Center	Does not need to be present during procedure
99090	Either	MD must read/review
99091	Either	>30 minutes of the MD time
95807-52	Either	None, apart from interpreting study
98960-98962	Either	Should order it, but not required to be physically present.

Best Practices:

- Have a sleep physician write an order for the procedure.
- Always have a sleep physician on-site as the 'supervising physician' to sign orders as needed for mask/pressure changes.
- Make sure you bill the code specific to your site (clinic, hospital-based lab, etc.).
- Include detailed notes on your interactions with the patient in the medical record to demonstrate what took place.
- Book slots for approximately one hour – some patients may need less time, but some will require more. Also, be sure to account for time doing paperwork, billing, etc.
- Never bill two codes for the same patient during the same 24-hour period between the lab and physician office.
- Download compliance data each time (if applicable).
- Assess the need to adjust PAP pressure or change expiratory pressure relief and humidity settings.
- Provide counsel on sleep hygiene.
- Perform mask-fitting education and assess for leaks.
- Discuss the impact of co-morbidities on sleep health.



Suggestions to get started:

- Assess which codes make the most sense based on your care setting.
- Consult with your billing coding, and compliance departments if you have them.
- If your lab uses an electronic medical record, you will need help tying these new codes to specific billing pathways.
- Bill some test codes to private payors.
- Start small – if you have only part time physicians, consider a half-day session when they’re already in the lab/clinic and can be available to you.
- If you work for a non-profit, consider recording this as a ‘community benefit,’ versus a billable item, which you provide to improve the health and wellness of your local population. Your hospital administration will be reporting this type of non-billed activity anyway.
- Remember, even if you can’t always bill, there are intangible benefits that come to the sleep center. Not only is it good patient care, but it helps improve patient and referring physician satisfaction. Most primary care and other non-sleep physicians like to send patients to full-service labs so they don’t have to worry about DME follow up and compliance.
- Look to your local coverage determination (LCD) and the national coverage determination (NCD) to comply with all government payor requirements. You may be getting paid now but risk having to give it all back with penalties if you didn’t follow all of the rules.
- Consider starting with employer-sponsored health plans (e.g. your own hospital, potentially), as it may be easier to justify this when your employer benefits from compliant patient/employees.

Selling a New Position to your Employer

Most companies aren't going to hire a new daytime person without a clear sense that this position can bring in new revenue. It will be important to model out the potential return on investment for hiring a clinical sleep educator. After reviewing reimbursement ranges (or better still, billing a test case or two of your own), consider putting together a financial model such as this:

Sample billable amount for G0462:	\$171
Collectable Amount (you often collect less than you bill due to waived copays, bad debt, negotiated rates)	\$100
Your daily wages at \$30/hr	\$240
Your total cost with benefits (which typically cost 30% of your salary)	\$312

How many patients do you have to run to justify your existence as a CSE or CCSH? In this model, the answer is just over three patients. You cost \$312 per day and you get \$100 per patient. If you saw three patients, the company would lose \$12 each day. If you saw four patients, you would earn your company an extra \$88 per day. Anything beyond the fourth patient would be additional profit. Do be realistic in how many patients you can see per day. Because you may be doing other paperwork (and probably need to take a break here and there), a good number to consider is six patients per day.



Conclusion

We hope that the information presented here can help you develop into the role of clinical sleep health specialist. Remember that this information is a snapshot of the current practices in the field at this time. There is considerable regional variation in payment as well as in documentation requirements. What's offered here is best practices to the best of our knowledge. It is important that you work with your institution's billing and coding experts, and that you stay abreast of your national and local coverage

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determinations to assure you are billing in a compliant manner. The BRPT does not employ coders and cannot give legal advice about specific questions.

Helpful Links

- [American Academy of Sleep Medicine Coding FAQs](#)
- [CMS Evaluation and Management \(E&M\) Service Guide](#)
- [Medicare Coding Guidance](#)
- [Medicare Administrative Contractors](#)
- [OPPS Guidance](#)