Incorporating CCSH into your Sleep Center

Presented by Nicholas Bashline, RPSGT, CCSH
The four keys to success
Brief history of the CCSH credential and of the CSE program

• The Clinical Sleep Educator certificate was first offered in 2012

• The CCSH credential first became available in 2016

• The BRPT published the Sleep Educator Reimbursement Guide in 2017

• Continued growth of the credential, by the end of 2021 there were over 2000 credential holders
• Earliest days of what would become the foundation of our current program were fairly basic. Mostly consisted of mask swap outs, walk in card reads and compliance reports

• Ground work was laid in 2017 with the reimbursement guide

• Officially launched in October of 2019

• From May of 2020 to May of 2022 - 860 arrived appointments

• We average about 50-60 patients as month

• The expectation is to easily surpass over 1100 total by year’s end

• As a result our compliance rate is 85-90%

• National compliance average is approximately 70%, a third of all patients will quit therapy in the first year
Objectives for today’s presentation

• When does patient education actually begin?
• Why would you want to pursue the credential?
• Various ways the CCSH credential can be utilized in a CSE program
• What does a CSE appointment look like, including documentation
• Reimbursement!
• Q&A, if time allows.
When does patient education begin and why is it becoming even more important?

• During the set up whether at night or during the HST appointment

• Prepares the patient for potential outcomes

• Proper education can help manage expectations

• Gives the patient reassurance help is available

• As HSTs become more and more the first line approach, patients need a resource

• Generally misgivings and misinformation can be corrected
How important can a CSE program be for patients?

• HST patients will miss out on certain benchmarks
• Insurance denials are becoming even more common
• A lot of devices are becoming drop shipped with “close enough” interfaces
• Reimbursement cuts at the DME level, more often than not, come at the cost of the patient’s education
• Shortage of RRTs
• Sleep technologists are a specialized group
• Recall replacements are usually not programmed to the patient’s current parameters
Why would you want to pursue the credential?
Ultimately, the end result is to help patients. The credential will not make you a better technologist.
No, really, why?

• Possible career advancement and job security or even creation at the cutting edge of sleep medicine
• A possible means of going to days
• An overall reduction in night studies
• Continued development and growth of AI scoring could impact scoring positions
• Still very early in the game! has been changing for some time
• Possible career advancement and job security, a means to justify going to days
• Most insurances require Home Sleep Testing as a first line approach. Most facilities have already seen a reduction to their in-lab numbers
• Uptick in A.I. scoring programs, may lead to a reduction in scoring positions
• Ultimately it is about patient care from providing a reliable source of information and education.
Selling points when discussing this with your provider or facility

• Cost savings in comparison to a NP or PA

• Unique approach to patient care, as these programs are not widespread

• A lot of services will be moving to, or already are, an outcome based model

• Provide an advantage for bundled services
How can the CCSH credential be utilized

- Machine checks and mask fittings, including set ups and recall replacement appointments
- Compliance report downloads
- Yearly returns
- Patient liaison between offices and DME companies
- Public education and health fairs
Clinical Sleep Educator Visit

Last name, First name
DOB:
MRN #:
Sex:

*** Last name, under the care of Dr. {Sleep Provider list }, was seen by me in the sleep clinic.

Reason for seeing the CSE, including concerns/complaints
Current device; to include modality, pressure and comfort settings, mask/tube selection and interface used
Compliance data, if applicable
Changes made to settings, options and interface.
Pressure trial
Total spent on appointment
Plan for follow up and expectation
Dr. {Sleep Provider list} in office and available for consult.

Nicholas Bashline, RPSGT, CCSH
Documentation for a CSE appointment in the EMR

- A referral must be in the system from the provider
- Referral must state the reason for the appointment request
- The template should start with *Patient’s name* is under the care of Dr. __
- Patient’s reason for being seen. Mask fit, pressure issues, compliance report, etc
- Current device, settings and interface
- Data summary for AHI, leak value, usage and any other notable information such as CSR or CA
• Summary of changes to pressure, comfort settings and interface as needed

• Follow up plan and expectations

• Time spent on the appointment

• For billing purposes the provider “is in the office and available for consult”

• Electronic signature and co-sign required
What does a CSE appointment look like?
• Contacted their DME company, and they actually referred the patient to come see me, as they were unable to help

• Multiple concerns. Including the pressure ramping up too high, machine shut off during use, difficulty using the machine at the beginning of evenings

• Additional concerns about insurance issues caused by switching to a previous device they still owned and the impact on compliance

• They also mention a recently developed whistling noise
Most often it is not the pressure that is the issue

- The starting pressure can in fact be too low, which could lead to air starvation
- The device may not be utilizing the comfort settings or tube and mask selection options
- The interface may be the wrong size/fit or the wrong style which can cause an Auto to increase “too high”
First stop. Settings check
EPR is off, Soft response is set
• Pressure range was set at 6-16cm. EPR was off with a Soft response

• 15 minute ramp starting at 4cm

• Patient wears a nasal pillow interface, with a full face selection
After adjustments
• The machine has not been turned on at this point so the whistling noise and mask fitting have not been addressed

• The ramp was turned off as well prior to the mask fitting, but for demonstration purposes it was turned back on

• Whistling noise is noted immediately once the patient started breathing

• Patient states they love their mask
Ramp turned on, on an Auto machine
Ramp turned off
Notice the circle is fully green
Often times this is when the device pressure will become more comfortable for the patient
• The whistling noise increases on the patient’s inhale, which can be a sign of an unapproved cleaner being used.

• I noticed the filter cover bouncing on the exhale. I opened the cover and the filter’s corner is pulling in the intake vent

• Once I removed the filter, the noise reduced substantially, but not 100%

• The patient likes the improved inhale sensation and the reduced noise but feels the pressure is still trying to “blow him up”, which brings us to…
Mask fitting

The patient loves his mask. In fact it is the only mask he’s used for 10 years!
It also happens to be the wrong sized pillows
• The left nasal pillow is going into their nostril so they are given a new interface. Going from a medium to a large size

• Within two breaths with the new interface, the patient states the “blowing up” sensation is gone

• The patient was very excited and actually asked if it’s “the simple?!”
Wrapping up the patient’s appointment

• The patient’s EPR was not on. Additionally it was on a Soft response

• 15 minute ramp at 4cm was causing them to struggle at the start of each evening

• Wrong sized pillows, even though the were subjectively comfortable

• Dirty, misplaced filter causing noise and impeding the operation of the device

• All of these various issues can impact the device and keep it from working properly for the patient

• The patient called back in about a week and told us that the “machine works better than he’s ever experienced and even better than his previous machine”
Reimbursement!
Sleep Educator Reimbursement Guide

Found on BRPT.org

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 there are new, evolving roles, there’s a lack of clarity and consistency in the field about how to bill for activities such as PAP dietizations, 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

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>FULL TERM</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
<td>The United States government division that administers the Medicare and Medicaid programs and sets rules for payments.</td>
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<tr>
<td>E&amp;M</td>
<td>Evaluation and Management</td>
<td>Billing codes which are typically used in the clinic or physician office setting.</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<tr>
<td>LCD</td>
<td>Local Coverage Determination</td>
<td>Medicare guidelines set at the regional level by a MAC.</td>
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<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
<td>Medicare utilizes private contractor organizations to oversee regional implementation of its programs. MACs often create multiple plans and may set additional requirements for reimbursement.</td>
</tr>
<tr>
<td>NCD</td>
<td>National Coverage Determination</td>
<td>Medicare guidelines for reimbursement in most provinces at a national level. The NCD supersedes the LCD in cases where they may conflict.</td>
</tr>
<tr>
<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
<td>Medicare payment rates and capitation rates for most outpatient hospital services.</td>
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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.
Specific E&M Codes

For our program we utilize 99211
Summary of CPT codes

Best practices will provide an overview of a program too.

<table>
<thead>
<tr>
<th>CODE</th>
<th>SETTING</th>
<th>PHYSICIAN ROLE</th>
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<tbody>
<tr>
<td>99211</td>
<td>Clinic/Physician office</td>
<td>Must be in building</td>
</tr>
<tr>
<td>99212</td>
<td>Clinic/Physician office</td>
<td>Must be in building</td>
</tr>
<tr>
<td>99213</td>
<td>Clinic/Physician office</td>
<td>Must be in building</td>
</tr>
<tr>
<td>99214</td>
<td>Clinic/Physician office</td>
<td>Must be in building</td>
</tr>
<tr>
<td>99215</td>
<td>Clinic/Physician office</td>
<td>Must be in building</td>
</tr>
<tr>
<td>94600</td>
<td>Sleep Center</td>
<td>Debate - may require 40 minutes of physician time</td>
</tr>
<tr>
<td>90463</td>
<td>Sleep Center</td>
<td>Does not need to be present during procedure</td>
</tr>
<tr>
<td>99000</td>
<td>Either</td>
<td>MD must read/review</td>
</tr>
<tr>
<td>99001</td>
<td>Either</td>
<td>&gt;30 minutes of the MD time</td>
</tr>
<tr>
<td>95807-52</td>
<td>Either</td>
<td>None, apart from interpreting study</td>
</tr>
<tr>
<td>98600-00982</td>
<td>Either</td>
<td>Should order it, but not required to be physically present</td>
</tr>
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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.
- E-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.
• 99211 does not require a physician to be present at the appointment

• The 99211 is, currently, the most appropriate CPT for what we do, and we have had a fair amount of success with getting reimbursed

• 99212 or higher requires a provider or Other Qualified Medical professional (OQMP) such as a PA, NP, etc be present for the appointment

• Other codes found in the guide may work for commercial payors

• Please check with your compliance/billing department for state or insurance specific guidelines
Where does that leave us and where can this go in the future?

• CMS to recognize the CCSH as an OQMP. While ideal, it would require continued growth in the CCSH education pathways including a Master’s level program

• The American Medical Association could create a CPT or multiple CPTs specific to Sleep Education and more appropriately defined to what a CCSH does

• Continued growth of the credential and programs through the country leading to recognition and proof positive outcomes

• According to the AASM in a December 2021 press release a record 179 physicians were matched with sleep medicine fellowships, which broke the previous record of 165 the year before.

• As there are approximately 7500 sleep facilities with about 2500 sleep professionals, an additional 150 a year is not enough
In conclusion

• Incorporating a CCSH program is fairly straightforward.

• Documentation is relatively simple.

• It is an art form that will evolve as new information, technology, and equipment come out.

• Absolutely vital and beneficial for patients.

• Even at the current CPT billing, the program provides some reimbursement over costs/employee wages, but at the end of the day it is about patient care and helping to assure the best outcome for the patient.