To the editor:

Within the past year, the Centers for Medicare and Medicaid Services (CMS) has reviewed the use of portable testing for the diagnosis of obstructive sleep apnea. The CMS had previously ruled that a diagnosis of obstructive sleep apnea-hypopnea syndrome (symptoms of disease and an apnea-hypopnea index > 5 or an apnea-hypopnea index > 15/hour) could be made only by an attended sleep study, thus precluding portable or unattended monitoring as an appropriate first step prior to titration of continuous positive airway pressure. The recent policy review included an extensive review of the literature by CMS, 2 periods of public comment, and finally a public hearing in which we, the American Sleep Apnea Association (ASAA), a nonprofit patient-advocate organization, participated. CMS reviewers concluded that “evidence is not adequate to conclude that use of unattended portable multi-channel sleep testing” can be supported at the present time in the evaluation of obstructive sleep apnea.

We remain concerned that many sleep apnea sufferers remain unrecognized and untreated, despite the availability of effective treatment. The ASAA seeks a broader perspective than that reflected in the CMS review. ASAA believes that new approaches will improve access and reduce barriers to therapy. The controversy generated between well-meaning professionals in this area suggests that both sides have legitimate concerns. The uncertainty associated with less physiologic data in portable recording must be balanced with the overwhelming clinical indicators in many patients with obstructive sleep apnea. Those of us, patient and physician, who have experienced diagnosis and treatment believe that in many instances the process inhibits care. Thus, emphasis should be placed upon those areas, like need for access at reduced cost for those with uncomplicated illness, where the experts agree rather than on disagreements. Evidence is increasing for associations of sleep apnea with other medical problems such as hypertension, diabetes, attention deficit disorder, heart disease, obesity, and stroke, suggesting that demand for sleep apnea recognition will continue to accelerate. Healthcare cost and insurance disparity will force a reevaluation of the relative value of center-based testing, as sleep apnea occurs in the home and must be managed in the home. Polysomnography is a resource that will have to be managed, as any other medical technology is managed.

We propose the following principles toward achieving a goal of sleep apnea identification and management:

1) All patients with sleep apnea should be guaranteed access to diagnosis and treatment, especially when financial limitations exist in the local healthcare system. In particular, all patients should have access to some type of reliable diagnostic study for sleep apnea, and this should be available within a 100-mile radius of their home and within 30 days of referral.

2) Patients should expect to have the same attention given their therapy and follow-up as was given to their diagnosis. When positive pressure therapy is prescribed, all resources available to the prescribing physician should be employed to ensure satisfactory outcomes with this therapy. Other therapeutic modalities need to be reviewed when treatment with first-line therapy fails. Documentation of successful outcomes in this setting is no different than in any other aspect of medicine and resides with the prescribing physician. Collaboration between the sleep specialist and other healthcare professionals will help the prescribing physician provide efficient care. Patients should be entitled to expect periodic follow-up and unfettered access to an appropriate specialist should problems arise.

3) Patients have the right to quality care, independent of where they receive it. This is especially the case when the outcome of at-home or portable testing does not confirm the clinical pretest suspicion of sleep apnea. Patients who undergo alternative methodology for sleep testing must also have access to currently accepted diagnostic tests until the alternative testing has been shown to have the appropriate predictive positive (for diagnostic) or negative (for screening) value when compared with currently accepted norms.

From this perspective, the issue of unattended versus attended conventional sleep-apnea recording needs to be redefined. Health maintenance organizations and other institutions (e.g., Veterans
Administration) that currently employ alternative testing should be strongly encouraged to report their experiences with the medical community in published form. Academic medical centers and major funding agencies should show interest in this area, which now is populated only by small studies with inconclusive results. Studies performed on new technologies have primarily addressed their ability to reproduce traditional indexes of sleep-disordered breathing rather than focusing on the effect the technology and the algorithm of its application have on patient outcomes. Research should emphasize patient outcome rather than focus on the number of apneas. The appropriate federal agencies should be encouraged to champion new initiatives in this area, which has the potential to have a large impact upon public health and disparities in access to care. Studies designed to compare innovative medical management programs should receive preferential funding.

Professional societies involved in sleep research and clinical investigation should foster dialogue on alternative healthcare delivery and testing systems and should take a lead role in evaluating and setting goals and targets to improve outcome. These organizations will serve more effectively if they foster innovation and broader physician participation of primary care providers in the recognition, treatment, and follow-up for this common illness.

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