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June 22nd, 2020

To whom it may concern:

This communication was created on behalf of the Payer Policy Review Committee of the American Academy of Sleep Medicine (AASM), a membership organization representing over 10,000 individual physician members and sleep centers. As the leading membership organization for sleep medicine, the AASM sets clinical standards for sleep medicine care by publishing new and updated evidence-based clinical practice guidelines annually. The Payer Policy Review Committee is comprised of physicians who are experts in the field of sleep medicine and well versed in AASM guidelines and relevant literature. This committee is charged with working to communicate the recommendations in the AASM guidelines to insurers and to assess insurer adherence to these guidelines.

We want to make you aware of the new position statement

Polysomnography for Obstructive Sleep Apnea Should Include Arousal-Based Scoring: An American Academy of Sleep Medicine Position Statement, published in the July 2018 issue of the *Journal of Clinical Sleep Medicine*. **The position statement emphasizes the position of the AASM that the RECOMMENDED AASM Scoring Manual scoring criteria for hypopneas, which includes diminished airflow accompanied by either an arousal or $\geq 3\%$ oxygen desaturation, be used to calculate the apnea hypopnea index (AHI); the sleep study metric used to measure the severity of sleep apnea.** The AHI is calculated by counting the number of apnea (complete or near complete cessation of airflow) events and hypopnea (partial reduction in airflow) events. In prior versions of the manual, a different scoring criteria for hypopneas had been recommended that required an association with $\geq 4\%$ oxygen desaturation (EEG arousal alone was not sufficient). The change in the recommended scoring criteria was proposed by the AASM Sleep Apnea Definitions Task Force after a review of the existing literature on clinical outcomes associated with using various scoring criteria. The task force outlined their rationale and supporting evidence for this change in a 2012 review paper.¹ The change was based on growing evidence that indicated that respiratory events linked with $\geq 3\%$ oxygen desaturation were as predictive of adverse outcomes (cardiovascular and metabolic) as respiratory events linked with $\geq 4\%$ oxygen desaturation. In addition, the Task Force cited evidence that sleep fragmentation without oxygen desaturation can be associated with symptoms and that treatment in these cases can improve symptoms and objective sleepiness.

While many payers have adopted the new recommendation regarding scoring criteria for hypopneas included in the AHI, the AASM is aware of several payers, including your company, that still require $\geq 4\%$ desaturation for hypopneas included in the AHI used for reimbursement of treatments for sleep apnea. This creates difficulties for both patients and clinicians. Symptomatic sleep apnea patients, including patients at risk for motor vehicle accidents, who meet current clinical definitions for the diagnosis of sleep apnea are potentially denied coverage for effective treatments like continuous positive airway pressure (CPAP). Sleep medicine specialists who follow the evidence-based recommendations of the AASM are forced to expend additional resources to score sleep studies using two different scoring criteria to satisfy the payers who have not updated their criteria. Also noteworthy is the additional confusion this creates for patients to whom the two AHI metrics must be explained.

For these reasons, we request that you consider updating your AHI definition to the one currently recommended by the AASM. If you have any questions regarding this, please contact AASM Director of Health Policy, Diedra Gray, at (630) 737-9700 or dgray@aasm.org.

Sincerely,

Kunwar Praveen Vohra, MD, MBA
Chair, AASM Payer Policy Review Committee