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EDITORIAL

A Warning Shot Across the Bow: The Changing Face of Sleep Medicine

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On January 23, 2013, Sleep HealthCenters (SHC) abruptly closed its doors, leaving over 30,000 patients without a sleep provider, over 170 people without jobs, and disrupting the provision of sleep care within an entire region of the country. As publically reported in the media,[1] it was an ignominious end to one of the largest sleep medicine practices in the country. The practice had long been regarded as a leader in the provision of comprehensive sleep services, utilizing a practice paradigm that was thought to be a model of excellence in patient care and cost effectiveness. As everyone affected by the closure scrambled to adjust to the situation, from patients unclear of where to get care or PAP supplies to doctors without access to medical records to hospitals and medical groups without vendors to provide sleep services, the most important questions are why did this happen and what does it mean for other sleep providers?

Several factors, all occurring in the same timeframe, likely contributed to the demise of SHC, in other words, the "Perfect Storm." First, over the past few years, there has been an overall decline in reimbursement rates and changes in reimbursement policy. For example, in 2010, CMS and other insurers decided not to recognize the CPT codes for outpatient consultations, thus requiring initial encounters with patients for whom a consultation was requested to be billed at the lower payment rate for a new patient visit. Simultaneously, there was a decline in the reimbursement for polysomnography (PSG).[2] Second, with the economic downturn starting 5 years ago, many patients either lost their employment and consequently their health insurance, or their out-of-pocket costs (higher co-pays and deductibles) increased. Given that sleep concerns are felt by many to be non life-threatening, evaluation for sleep problems were delayed or never scheduled. Third, with refinement in out of center sleep testing (OCST) technology for establishing the diagnosis of obstructive sleep apnea (OSA), use of these devices became accepted in the American Academy of Sleep Medicine practice parameters.[3,4] Concomitantly, autotitrating positive airway pressure devices were shown in most cases to satisfactorily treat patients with OSA without the requirement for an in-laboratory titration study.[5,6] Consequently, insurers in Massachusetts rapidly embraced ambulatory testing for OSA requiring pre-authorization for both OCST and PSG. The requirement for pre-authorization led to an increase in OCST, but a decrease in PSG. With some insurers, up to 75% shifted to home studies with a matching decline in the number of PSGs and a marked decline in PSG revenue that was not offset by the increase in OCST. As a result, SHC was left with long-term leases on a substantial amount of unused sleep laboratory capacity. As the effects of these changes in reimbursement became evident, SHC began to change its practice model, embracing OCST and developing practice models to integrate sleep services within established primary care practices. They attempted a managed downsizing, with closing of centers and reduction in nighttime and administrative personnel. In addition, as revenues declined and were outpaced by expenses, SHC attempted to negotiate new arrangements with its vendors, clinical affiliates, and landlords but was not universally successful. Despite these measures, as with any business enterprise where expenses continue to exceed revenue, the end came. Unfortunately for patients and employees, it was disturbingly abrupt with little planning for any transition of care.

What can Sleep Medicine providers learn from demise of SHC? First, it is important to realize that the days of performing an in-laboratory PSG on most patients are numbered. Although the use of pre-authorization for OCST and PSG was pioneered in Massachusetts, it will rapidly spread across the nation because insurers will recognize the cost savings to them. It will not be prudent to be "an ostrich with its head in the sand." Second, if OCST is coming, Sleep Medicine practices need to be proactive in developing the capability to perform high quality OCST testing. This means conversations with insurers to establish guidelines or care pathways that follow existing evidence-based clinical guidelines, respect the importance of the Sleep Medicine specialist and provide access to diagnostic and treatment modalities for all patients. Third, Sleep Medicine practices need to evaluate their own business plans. Although there will likely be a need for in-laboratory testing for a small number of patients in the foreseeable future, reliance on laboratory PSG as a primary revenue stream will become increasingly nonviable. Fourth, diversification of services should be considered such as provision of durable medical equipment, sleep wellness programs, and compliance management programs. Finally, there will be a need to emphasize the evaluation and management patients, an aspect of practice that is sometimes overshadowed by the attractiveness of new diagnostic technologies.

As a specialty, Sleep Medicine holds many attractions. Sleep disorders are common, and most patients can be successfully treated with resultant improvement in quality of life and a decrease in the risk for other diseases. The field encompasses an interesting blend of pulmonary and neurophysiology, psychia-

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try, psychology, and pharmacology. However, to be attractive, it needs to be economically viable for its practitioners. What we have learned in the past several months from the demise of SHC is that the old paradigm will no longer work. A new one needs to be established lest the specialty lose control of its own fate and the progress that has been made in getting the public and the field of medicine to recognize the importance of sleep to good health is lost.

CITATION

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