

HERC Coverage Guidance – Treatment of Sleep Apnea in Adults Disposition of Public Comments

General Comments

Stakeholder	#	Comment	Disposition
<i>Medical Director, Health Plan</i> Portland, OR	1	Regarding the Coverage Guidance, I have several suggestions for consideration. First would be to enhance the statement regarding excessive daytime sleepiness to require an objective evaluation of daytime sleepiness, presumably the Epworth Sleepiness Scale. This would avoid the subjectivity involved in any statement on the part of provider or DME supplier claiming member has “excessive sleepiness”, without requirement of at least a standardized assessment. Likewise, “impaired cognition” is problematic in its subjectivity, although probably not wise to try and establish a standardized requirement for that condition, as it would likely lead to neuropsych testing requests, which would be of limited value in many cases (particularly if no baseline exists, as would be the case in almost every situation).	Thank you for your comment. Guidance changed to incorporate ESS into coverage guidance box. Eight trials evaluated the effect of CPAP on neurocognitive or psychological tests, all found significant benefit from CPAP. Reference to impaired cognition has been deleted from the guidance box.
	2	It might be of value to consider whether provider needs to test for alcohol use, as recommendations for abstinence from alcohol is a standard recommendation whether or not a patient is using CPAP.	Evidence source does not address this, except to list avoidance of alcohol as the conservative management arm compared to surgery.
	3	It might also be of value to specify that the provider education should cover avoidance of alcohol, avoidance of CNS-affecting medications, and the contribution of obesity to OSA, when applicable. It could even be required to document (by requesting provider) that a review of medications has been performed, focusing on current use of contraindicated medications, and avoidance of them in the future.	Evidence source does not address this, except to list weight loss, positional therapy, and avoidance of alcohol and sedatives as the conservative management arm compared to surgery. Regarding obesity, three trials of weight loss interventions (primarily diets) found a significant improvement in AHI, ESS and O2 saturation. Regarding provider education, 9 studies evaluated extra support or education to improve compliance with CPAP, however results were inconsistent. Counseling regarding weight loss has been added to the guidance box.
	4	I also believe the literature suggests that compliance with CPAP can be predicted in most cases by usage in the first few weeks, if not sooner. Is there need to have the trial period be 12 weeks-that would seem to be excessive, and given the likely high rate of non-compliance, is a 3 month trial necessary? It seems not, and a significant cost to the system. A shorter trial period might also promote the DME supplier to ensure member awareness of compliance requirements. I would propose a two-stage trial period-the first of 4-6 weeks to establish compliance, and if that first criteria is met, a second criteria at 12-16 weeks to evaluate for effectiveness.	The evidence source identified 5 studies that evaluated predictors of compliance, which included higher AHI, higher ESS score, younger age, snoring, lower CPAP pressure, higher BMI, higher mean oxygen saturation. One of those trials evaluated compliance at 4 weeks and found the only significant predictor to be high baseline AHI. There was a small (3%) decrease in the number of patients compliant with CPAP use between 4 weeks and 12 weeks. No other trials evaluated compliance or predictors of compliance at 4-6 weeks.

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	5	It also might be helpful to objectify “effectiveness” or clinical benefit if possible. Thank you for your consideration.	Effectiveness is explained in the text, as follows: “sufficient evidence supporting large improvements in sleep measures with CPAP compared with control (e.g., reducing apnea hypopnea index (AHI), improving symptoms as measured by the Epworth Sleepiness Scale, reducing arousal index, and raising the minimum oxygen saturation). Weak evidence demonstrated no consistent benefit in improving quality of life, neurocognitive measures or other intermediate outcomes.”
Industry Location Unknown	6	In response to the draft coverage guidance: Treatment of sleep apnea in adults, I guess my first response would be; is this the full policy? It appears that it may be a summary of medical necessity but does not have guidelines which currently exist in this policy such as when to bill for the sale of the item. For example the current policy has "a three month trial (rental) period for CPAP is required prior to purchase", the draft does not mention a change in therapy, existing policy states "If a CPAP device was used more than three months and the client is switched to a RAD, then the clinical re-evaluation would occur between the 61st and 91st day following initiation of the RAD".	This document provides general guidance only. Specific implementation of the policy is left to individual payers.
	7	I guess my overall confusion is what is the reasoning for the "draft" is it just in terms of medical appropriateness and nothing further or is the "draft" intended to replace the current rule? If it is intended to replace the current rule it appears to be missing many factors that are vital to providers. Thank you.	Yes, the intent is to address general medical appropriateness, not to replace the current DMAP rule.