

These comments are limited to the Valuation of Specific Codes for CY 2027: Unattended Sleep Testing section of the Physician Fee Schedule proposed rule.

Code	Long Descriptor
95X18	Unattended sleep study, set-up, data acquisition and technical analysis; low complexity of 3-4 channels that generate at least 3-5 parameter categories
95X19	Unattended sleep study, set-up, data acquisition and technical analysis; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories
95X20	Unattended sleep study, set-up, data acquisition and technical analysis; high complexity of 11 or more channels that generate at least 9 parameter categories
95X21	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; low complexity of 3-4 channels that generate at least 3-5 parameter categories
95X22	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories
95X23	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; high complexity of 11 or more channels that generate at least 9 parameter categories

CPT Codes 95X18, 95X19, and 95X20

The AASM agrees with the RUC's conclusions regarding CA021 and CA042 and believes the recommended incremental increases appropriately reflect typical clinical practice.

With respect to CA021, patients typically present to the sleep center to receive equipment, review instructions, watch a demonstration of how to apply the equipment, and perform a test run of the device before the study. The demonstration and training have historically reduced failure rates and required more time as equipment complexity increases. Higher-complexity studies also require additional patient instruction, the application of respiratory effort belts and sensors, equipment fit customization, and verification that patients can correctly self-apply the equipment at home. These activities support the RUC recommendation of 15 minutes for CPT codes 95X18 and 95X19 and 25 minutes for CPT code 95X20. These patient-facing activities are integral to obtaining a technically adequate study on the first attempt. If the clinical staff time required for individualized education, sensor placement instruction, fit adjustment, and test application is undervalued, practices may have fewer resources to prevent technically inadequate studies and repeat testing.

Similarly, the CA042 recommendations appropriately reflect the work performed after the device is returned. The download, scoring review, quality assurance activities, preparation of physician summaries, and cleaning and repackaging of reusable equipment increase as study complexity increases. The RUC agreed with the specialty societies that the recommended inputs are appropriate and reflective of typical clinical practice. For CPT

codes 95X18, 95X19, and 95X20, the recommended clinical staff times of 40, 50, and 70 minutes, respectively, reflect the combined work of downloading study data, conducting first- and second-pass manual review by a respiratory technician, preparing a summary for the interpreting physician, and cleaning and repackaging reusable equipment. The Subcommittee agreed that automated summaries are not sufficient for accurate interpretation and that manual scoring of all channels and events remains necessary and is supported by the medical literature. Automated output must be reviewed against the full physiologic record to identify artifacts, verify signal quality, confirm respiratory events, and reconcile discrepancies across channels before the study is presented for physician interpretation. Automated summaries may help but do not replace the trained technologist's manual review and quality-assurance responsibilities. Members also confirmed that download time appropriately increases across the code family because each code involves different software applications, increasing channel complexity, and more than eight hours of recorded data. Likewise, cleaning and repackaging time increases with each code due to the additional respiratory belts and device components requiring disinfection and preparation for reuse. This activity is separate and distinct from CA024, Clean room/equipment by clinical staff, and there is no overlapping respiratory technologist work during the service period. Based on these considerations, the AASM strongly recommends 40 minutes of CA042 for CPT code 95X18, 50 minutes for CPT code 95X19, and 70 minutes for CPT code 95X20, in agreement with the RUC recommendations. Accordingly, the AASM urges CMS to finalize the RUC-recommended CA021 and CA042 inputs without refinement.

Equipment Time

The AASM supports the RUC recommendation of 960 minutes of equipment time for CPT codes 95X18 through 95X20. As discussed during the RUC review, the 16-hour period reflects typical clinical workflows, established RUC database conventions, and the fact that the equipment is dedicated to a specific patient and unavailable for use by another patient during that time. The relevant consideration is not limited to the device's active recording time, but rather the entire period during which the equipment is committed to the patient's care.

For example, a patient may visit the sleep center in the late afternoon to receive the device, complete equipment training, and perform a test application before returning home. The study is then conducted overnight, and the patient may not return the equipment until the following morning or later that day. Throughout this entire period, the equipment remains assigned to that individual patient and cannot be redeployed for another study, regardless of the number of hours spent actively recording physiologic data.

Accordingly, the 960-minute equipment time accurately reflects typical operational use of unattended sleep testing devices and the period during which the equipment is unavailable for alternative clinical use. The AASM therefore agrees that 960 minutes is representative of standard practice and should be retained.

Supply and Equipment Pricing

The AASM appreciates CMS' request for additional invoices for the new supply and equipment items associated with CPT codes 95X18 through 95X20. We agree that a single invoice may not adequately represent prevailing market costs and encourage CMS to continue accepting supplemental pricing information from manufacturers, suppliers, sleep centers, and other stakeholders.

Rather than reducing pricing assumptions based upon limited available data, we strongly urge CMS to consider all additional invoices submitted during rulemaking to ensure that pricing accurately reflects current acquisition costs. For example, the invoice currently included is for a reusable test and does not capture the rising number of disposable tests being utilized by clinicians, as evidenced by data submitted by an interested party to the 2026 physician fee schedule proposed rule. Updated market information may support higher direct PE valuations for the equipment and supplies associated with these services and help ensure continued beneficiary access to high-quality unattended sleep testing. Consistent with CMS' solicitation, the AASM encourages consideration of additional invoices for supply item SA143 and equipment items EQ417, EQ418, and EQ419 when determining final PE pricing.

CPT Codes 95X21, 95X22, and 95X23

The AASM appreciates CMS' acceptance of the RUC-recommended work RVUs for CPT codes 95X21 and 95X22. However, we urge CMS to finalize the RUC-recommended work RVU of 1.60 for CPT code 95X23 to maintain relativity within the code family and appropriately recognize the physician work associated with the most complex unattended sleep study interpretation service.

CMS is proposing a work RVU of 1.42 based on a crosswalk to CPT code 92014 (Ophthalmological services). The AASM has reviewed this crosswalk and does not believe it accurately reflects the physician work required to interpret an unattended sleep study involving 11 or more channels that generate at least nine parameter categories. The work of interpreting a high-complexity unattended sleep study requires integrated review of multiple synchronized physiologic signals, assessment of signal artifact and data adequacy, identification and characterization of respiratory events, correlation of findings

across parameter categories, and synthesis of those findings into a diagnostic report. An ophthalmologic examination does not involve the same form of prolonged multichannel physiologic data review or signal integration. The CMS crosswalk appears to have been selected primarily because it yields a lower intensity value, even though the surveyed service has time values very similar to those of the RUC-recommended crosswalk code. The AASM feels strongly that the RUC-recommended crosswalk to MPC code 99203 more appropriately reflects the physician work, clinical decision-making, and cognitive effort associated with furnishing this service.

We are particularly concerned about CMS' assertion that a work RVU of 1.60 would create an intensity level that is not typical for CPT codes 95X21 and 95X22. CPT code 95X23 represents the most comprehensive and complex service within this family and requires interpretation of substantially more physiologic information than the lower-complexity services. In addition, the surveyed code may include approximately twice as many channels and parameter categories as the lowest-complexity code in the family. The resulting increase in physician work, clinical judgment, and interpretation effort justifies a higher work RVU.

Further, the RUC recommendation of 1.60 is already conservative. CMS acknowledges that the RUC-recommended work RVU is below the survey 25th percentile of 1.75. Reducing the valuation below an already conservative benchmark risks undervaluing the physician work required to provide this service. Therefore, the AASM believes that assigning a value below the survey-based recommendation fails to adequately reflect the total physician work, intensity, and clinical judgment involved in the service.

The AASM also feels that the comparison services cited during the RUC review process, including CPT codes 74176, 93351, and 78452, demonstrate that a work RVU of 1.60 is reasonable and appropriate given the similar intra-service and total physician times associated with those services. These comparator services support the conclusion that the RUC-recommended valuation appropriately recognizes the complexity and physician work associated with CPT code 95X23. The AASM urges CMS to finalize the RUC-recommended work RVU of 1.60 for CPT code 95X23.

Analytic Crosswalk Error

The CY 2026–CY 2027 Analytic Crosswalk, published along with the proposed rule supplemental documents, incorrectly maps the new unattended sleep testing codes. Specifically, codes 95X18 and 95X21 should crosswalk from CPT 95800, while codes 95X19 and 95X22 should crosswalk from CPT 95806. The AASM respectfully requests that CMS update the utilization data analytic crosswalk in the proposed rule to ensure that the code

mapping accurately reflects the recommendations developed through the RUC process. As currently proposed, the analytic crosswalk incorrectly assigns a disproportionate share of Independent Diagnostic Testing Facility (IDTF) utilization to the moderate-complexity codes rather than the low-complexity codes. This misalignment has meaningful reimbursement implications because CMS relies on the utilization crosswalk to determine the specialty mix used for indirect practice expense (PE) allocation when calculating PE RVUs. Inaccurate assignment of IDTF volume, which is associated with a substantially lower indirect practice cost index (IPCI) than physician-based specialties, artificially depresses the proposed PE RVUs for the moderate-complexity codes while inflating the PE RVUs for the low-complexity codes. To ensure that payment rates accurately reflect the RUC recommendations and the underlying practice expense resources required to furnish these services, AASM urges CMS to correct the analytic crosswalk in the final rule.

G Codes (G0398, G0399, G0400)

CMS implemented HCPCS Level II codes G0398, G0399, and G0400 in 2008; these codes have been outdated since the Category I sleep testing codes were initially established in 2011. AASM believes that the new unattended sleep testing CPT codes, 95X18–95X23, are adequate for reporting unattended sleep testing procedures. The AASM, therefore, supports the RUC recommendation to delete G codes G0398, G0399, and G0400.