August 12, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: File Code CMS-1850-P, Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule for CY 2027

Submitted electronically via regulations.gov

Dear Administrator Oz:

The American Academy of Sleep Medicine (AASM) appreciates the opportunity to comment on the Calendar Year (CY) 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule. The proposed revisions will directly impact the care provided by AASM members to patients with sleep disorders. The comments included in this response directly reflect the needs of more than 9,000 individual AASM members and 2,400 AASM-accredited sleep programs, dedicated to advancing sleep care and enhancing sleep health to improve the lives of patients with sleep disorders, including the Medicare population.

Ambulatory Payment Classification (APC) Assignment for Revised Unattended Sleep Testing Codes

The AASM appreciates CMS's recognition of the revised Current Procedural Terminology (CPT) code family describing unattended sleep testing services beginning in CY 2027. The revised code set represents a significant modernization of the coding framework for home sleep disorder testing by distinguishing services based on the technology utilized, physiologic parameters acquired, and clinical complexity of the diagnostic evaluation. However, we are concerned with CMS's proposal to assign both the moderate-complexity and high-complexity unattended sleep testing services to the same Ambulatory Payment Classification (APC). We respectfully urge

CMS to reconsider this proposal because it does not appropriately recognize meaningful differences in hospital outpatient resource utilization that were fundamental to the development of the revised CPT code family.

In collaboration with the American Academy of Neurology, American College of Chest Physicians, and American Thoracic Society, the revised unattended sleep testing codes were developed through extensive clinical review and stakeholder input. The AMA CPT Editorial Panel approved a six-code family that replaces CPT codes 95800, 95801, and 95806 and was specifically designed to distinguish services that differ in the number and sophistication of physiologic signals acquired, diagnostic capabilities, and the resources required to furnish the service. These distinctions were not created solely for coding convenience; they reflect meaningful differences in the technology, equipment, supplies, and operational resources necessary to perform increasingly complex unattended sleep studies. Accordingly, the revised code family recognizes that not all unattended sleep testing services consume equivalent resources.

CMS has long stated that APCs are intended to group services that are both clinically similar and require comparable hospital resources. Assigning the moderate-complexity and high-complexity unattended sleep testing services to the same APC appears inconsistent with this principle. CPT code 95X19 describes a moderate-complexity study using 5 to 10 channels that generate at least 6 to 8 parameter categories, whereas CPT code 95X20 describes a high-complexity study using 11 or more channels that generate at least 9 parameter categories. High-complexity unattended sleep testing services generally require more sophisticated diagnostic equipment, expanded physiologic monitoring capabilities, more advanced data acquisition and analysis systems, and greater operational support than moderate-complexity studies. These differences may include:

- recording devices capable of acquiring and synchronizing 11 or more channels across at least 9 physiologic parameter categories;
- expanded sensors, patient interfaces, and related disposable supplies;
- higher equipment acquisition and replacement costs;
- increased maintenance and calibration requirements;
- enhanced software, signal processing, scoring, and data management capabilities; and
- additional technical resources for device preparation, quality assurance, and data management.

Collectively, these resource differences support separate payment recognition under the OPPS whenever hospital cost data demonstrate meaningful differences in resource consumption.

Alignment with the Physician Fee Schedule

The AASM also notes that CMS, in the CY 2027 Medicare Physician Fee Schedule proposed rule, proposed distinctly different direct practice expense inputs for the revised unattended sleep testing code family: 1.88 RVUs for the moderate-complexity service (95X19) and 4.47 RVUs for the

high-complexity service (95X20). Those proposed direct practice expense inputs reflect that the revised services require differing equipment, supply, and clinical labor resources. While the methodologies governing the Physician Fee Schedule and the OPPS differ, both payment systems seek to appropriately recognize the resources necessary to furnish Medicare services. Maintaining distinctions in resource utilization under the Physician Fee Schedule while collapsing moderate- and high-complexity services into a single APC creates an inconsistency in Medicare payment policy that may not accurately reflect hospital outpatient resource costs.

Appropriate payment is essential to ensuring beneficiary access to clinically appropriate diagnostic testing. If hospital outpatient departments receive equivalent facility payment for services requiring substantially different resources, hospitals may be discouraged from investing in more advanced unattended sleep testing technologies or offering higher-complexity diagnostic services when clinically indicated. This concern is especially important for Medicare beneficiaries who may benefit from expanded physiologic monitoring, including patients with complex clinical presentations and those who face barriers to traveling to an attended sleep laboratory. Rural and underserved communities may be particularly affected when a hospital outpatient department is one of the limited local sources of sleep diagnostic services. Inadequate differentiation could also encourage selection of a lower-resource test based on payment rather than the patient's diagnostic needs, potentially leading to inconclusive testing, repeat testing, or delayed diagnosis.

The revised CPT code family was developed to improve the accuracy with which unattended sleep testing services are described and valued, and OPPS payment policy should similarly recognize meaningful differences in hospital resource utilization whenever supported by available cost information. The AASM respectfully requests that CMS reconsider the proposed APC assignments for the revised unattended sleep testing code family.

Specifically, we recommend that CMS:

- Assign CPT codes 95X19 and 95X20 to separate APCs for CY 2027 because their clinical specifications and resource requirements are not comparable;
- review available cost data and other supporting evidence to accurately assign the resources required to furnish each of these services.

Because CPT codes 95X19 and 95X20 are newly established for CY 2027, historical claims mapped from deleted or predecessor codes cannot fully capture the different channel counts, physiologic parameter categories, equipment, supplies, labor, and technical analysis requirements now specified for each complexity level. A common APC based primarily on historical claims therefore risks assuming resource equivalence before hospitals have had an opportunity to report costs under the new code structure. If CMS determines that existing claims data are insufficient because these services are newly established CPT codes, we encourage the agency to assign the complexity levels to separate APCs and continue evaluating hospital cost information as it becomes available.

The AASM appreciates CMS's continued efforts to modernize Medicare payment policies for sleep medicine services, which aligns with CMS's broader goals of expanding access to high-quality care in the home setting, reducing patient burden, and promoting the use of innovative diagnostic technologies. We believe that recognizing meaningful differences in hospital resource utilization among the revised unattended sleep testing services will improve payment accuracy, support appropriate adoption of advanced diagnostic technologies, and help ensure Medicare beneficiaries maintain access to the full spectrum of clinically appropriate sleep diagnostic services.

Thank you for your consideration of these comments. We welcome the opportunity to work with CMS as implementation of the revised unattended sleep testing code family proceeds. Please feel free to contact Diedra Gray, AASM Director of Quality & Health Policy, at dgray@aasm.org or 630-737-9700, for additional information or clarifications.

Sincerely,

Fariha Abbasi-Feinberg, MD
President, AASM

cc: Steve Van Hout, MBA, CAE
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