Obstructive Sleep Apnea

Provider’s guide to diagnose and code sleep apnea

Sleep apnea is a common disorder that by definition is characterized by a reduction in normal breathing during hours of sleep, often related to the collapse of the soft tissues in the back of the throat. Obstructive sleep apnea (OSA) is the most common sleeping disorder. It has been diagnosed in 3 to 7% of Americans. It is estimated that 20% of the entire American population has not been diagnosed.

Independent risk factors for developing OSA include:

› Obesity (BMI > 30 kg/m²)
› African-American race
› Male gender
› Advancing age
› Cranio-facial anomalies
› Smoking
› Controlled substance use and alcohol intake
› Chronic medical conditions such as: end-stage renal disease, congestive heart failure, chronic obstructive pulmonary disease (COPD), and stroke

Common symptoms of OSA include:

› Daytime sleepiness, including falling asleep while driving
› Snoring
› Restlessness
› Snorting
› Fatigue
› Headaches
› Poor concentration
› Nocturnal angina
› Choking
› Gasping
› Smothering
› Witnessed apnea by the patient’s bed partner
› Restless leg syndrome

When reviewing these symptoms it is helpful to clarify the history with the patient’s sleeping partner, when available. The most useful symptom for identifying patients with OSA is nocturnal choking or gasping. Snoring alone is not a diagnostic predictor for OSA. However, the lack of snoring and/or presence of apnea reduce the likelihood of an OSA diagnosis.

Quantification of the patient’s perception of daytime sleepiness and/or fatigue is an important historical finding. This can be determined by using the Epworth Sleepiness Scale (epworthsleepinessscale.com). A score of 10 supports the hypothesis of excessive daytime sleepiness, which should prompt the clinician to have the patient tested for OSA.

The physical examination should focus on:

1. Review of the oral airway, specifically: the size of the uvula and tonsils, and the presence of nasal septal deviation
2. Neck and waist girth – OSA is common in a neck size of 16 inches or greater
3. Assessment of blood pressure
4. Signs of pulmonary hypertension – nail bed cyanosis/clubbing, jugular venous distention (JVD), lower extremity edema, and/or ascites

When there is sufficient evidence to suspect OSA the patient needs to have a confirmatory examination to make the diagnosis. The diagnosis for OSA is determined by a polysomnogram (PSG), which is performed at a sleep center. Other testing such as a home based study can be performed, but this modality should be reserved for patients who have none or few co-morbid conditions.
Treatment for sleep apnea is a chronic disease, and therefore requires long term management. Compliance for treatment is low, and has been shown to improve with a multi-disciplinary approach, such as implementing a health coaching strategy. Utilization with a continuous positive airway pressure (C-PAP) device has been shown to reduce cardiovascular morbidity, i.e. improvement in hypertension and reduction in cardiac dysrhythmia. Successful treatment circumvents the OSA pathophysiologic driver of the sympathetic surge, which results in higher blood pressures and tachycardia. Patients should be encouraged to lose weight in addition to daily C-PAP utilization.

Coding for sleep apnea can be a challenge. Therefore provider documentation is paramount. The following table is a helpful guide:

<table>
<thead>
<tr>
<th>2015 ICD-10-CM</th>
<th>ICD-10-CM Description</th>
<th>Helpful hints</th>
</tr>
</thead>
<tbody>
<tr>
<td>G47.33</td>
<td>Sleep apnea, unspecified</td>
<td>Must be able to prove a history of obstruction (i.e. positive sleep study results)</td>
</tr>
<tr>
<td>G47.30</td>
<td>Obstructive sleep apnea (adult) (pediatric)</td>
<td>Non-specific form of apnea, which is not linked to obstruction</td>
</tr>
<tr>
<td>Z99.89</td>
<td>Dependence on other enabling machines and devices</td>
<td>Used to code dependence of the C-PAP device</td>
</tr>
</tbody>
</table>

As mentioned there are other conditions that contribute to the diagnosis of OSA. The primary disease state that contributes to OSA is obesity. Below is a table that will serve as a helpful coding guide:

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<th>2015 ICD-10-CM</th>
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<tbody>
<tr>
<td>E66.01</td>
<td>Morbid (severe) obesity due to excess calories</td>
<td>Diagnosed as a BMI ≥ 40</td>
</tr>
<tr>
<td>E66.2</td>
<td>Morbid (severe) obesity with alveolar hyperventilation</td>
<td>Diagnosis made with a BMI ≥ 40</td>
</tr>
<tr>
<td>Z68.4-</td>
<td>Body mass index (BMI) 40 or greater, adult</td>
<td>(-) Add 5th character: 1 – 40.0-44.9, 2 – 45.0-49.9, 3 – 50.0-59.9, 4 – 60.0-69.9, 5 – 70 or greater</td>
</tr>
</tbody>
</table>

Adding to the co-morbid complexity of OSA cardiac dysrhythmias can exacerbate or may be newly diagnosed as a result of untreated sleep apnea. It is important to consider coding these conditions as well.

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</tr>
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<tbody>
<tr>
<td>I48.0</td>
<td>Paroxysmal atrial fibrillation</td>
</tr>
<tr>
<td>I48.1</td>
<td>Persistent atrial fibrillation</td>
</tr>
<tr>
<td>I48.2</td>
<td>Chronic atrial fibrillation (permanent)</td>
</tr>
<tr>
<td>I48.91</td>
<td>Unspecified atrial fibrillation</td>
</tr>
<tr>
<td>I48.3</td>
<td>Typical atrial flutter</td>
</tr>
<tr>
<td>I48.4</td>
<td>Atypical atrial flutter</td>
</tr>
<tr>
<td>I48.92</td>
<td>Unspecified atrial flutter</td>
</tr>
</tbody>
</table>

Additional documentation and coding tips:

› Provide clear and concise documentation
› If known, link OSA to other associated medical conditions
› When making a diagnosis, also provide a treatment plan, for example: OSA – treated with C-PAP

References:

