Clinical Policy: Sleep Studies and Polysomnography Services

Reference Number: WNC.CP.284 Coding Implications
Last Review Date: 08/24 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Polysomnography (PSG) and sleep studies are used to diagnose sleep disorders and record nighttime sleep patterns. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging. Polysomnography records brain waves, the oxygen level in blood, heart rate, breathing, eye and leg movements during the study.

Polysomnography is usually done at a sleep disorders unit within a hospital or at a sleep center. Polysomnography is occasionally done during the day to accommodate shift workers who habitually sleep during the day.

In addition to helping diagnose sleep disorders, polysomnography may be used to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP).

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover the **Medically Necessary** Sleep Studies and Polysomnography Services, when the Member and facility meet the following specific criteria:

- **A.** A **supervised polysomnography or sleep study** performed in a sleep laboratory may be considered medically necessary as a diagnostic test for a Member who presents with any ONE of the following:
  1. Narcolepsy or Idiopathic Hypersomnolence;
  2. Sleep Apnea;
  3. Parasomnia;
  4. Periodic Limb Movement Disorder (PLMD);
  5. Chronic Insomnia (as defined in Background I.A.)when at least ONE of the following conditions is met:
     - a. Diagnosis is uncertain;
     - b. Sleep related breathing disorder or periodic limb movement disorder is suspected;
     - c. The member is refractory to treatment;
     - d. Violent behaviors are comorbid; or
     - e. Circadian dysrhythmias complicate the clinical picture.

6. Snoring with an underlying physiology from Criteria IV.; or
7. Congenital or Sleep Related Hypoventilation and Hypoxemia, **AND**
8. Supervised polysomnography services must be provided in a sleep facility (sleep centers with both a clinic and laboratory) that is accredited by The American Academy of Sleep Medicine (AASM), The Joint Commission (Formerly the Joint Commission on Accreditation of Healthcare) or the Accreditation Commission for Health Care (ACHC).

B. Home Sleep Test (HST) or Unattended Sleep Studies. Medicaid and NCHC shall cover Unattended Sleep Studies ONLY for the diagnosis of OSA, when:

1. One of the following devices are used:
   a. Type II: Comprehensive, portable sleep study Minimum of seven parameters including EEG, EOG, chin EMG, ECG or heart rate, airflow, respiratory effort, oxygen saturation;
   b. Type III: Modified portable sleep apnea testing Minimum of four parameters, including ventilation (at least two channels of respiratory movement, or respiratory movement and airflow), heart rate or ECG, and oxygen saturation); **OR**
   c. Type IV: Monitors and records a minimum of 3 channels that allow direct calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) as the result of measuring airflow or thoracoabdominal movement; or
   d. A device using Peripheral Arterial Tone (PAT), oximetry and actigraphy.
2. Service must be provided by a physician who meets all eligibility qualifications for participation in Section 6.0.
3. The test must be interpreted by a physician qualified to read full sleep studies.
4. All of the raw data must be examined by the reading physician.
5. The test must gather a minimum of six hours of data collected during the Member's usual sleeping period.
6. The Member meets the following criteria:
   a. High pretest probability of OSA with at least four (4) of the following symptoms are considered to be at high risk for OSA:
      i. Habitual snoring;
      ii. Observed apneas;
      iii. Wakes choking and gasping for air;
      iv. Morning headaches;
      v. Excessive daytime sleepiness; and
      vi. A body mass index greater than 35
7. OSA is suspected and in-laboratory PSG is not possible or diagnosis of OSA has been established, therapy has been initiated, and response to treatment is to be evaluated, and no significant co-morbid conditions exist that could impact the accuracy of the study (See Section 4.2.1 c.) or no sleep disorders

other than OSA are suspected (central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders, narcolepsy).

II. Repeat Polysomnography for Diagnosing Sleep Apnea

WellCare of North Carolina® shall cover a repeat polysomnography for diagnosing sleep apnea, when the required documentation to justify the medical necessity for the repeated test is provided, and **ONE** of the following criteria are met:

- **A.** The first study is technically inadequate due to equipment failure;
- **B.** The Member could not sleep or slept for an insufficient amount of time to allow a clinical diagnosis;
- **C.** The results were inconclusive or ambiguous; **OR**
- **D.** Initiation of therapy or confirmation of the efficacy of prescribed therapy is needed.

III. Follow-up Polysomnography

WellCare of North Carolina® shall cover follow-up polysomnography when **ONE** of the following criteria are met:

- **A.** After substantial weight loss has occurred in patients on CPAP for treatment of sleep-related breathing disorders to ascertain whether CPAP is still needed at the previously titrated pressure;
- **B.** After substantial weight gain has occurred in patients previously treated with CPAP successfully, who are again symptomatic despite the continued use of CPAP, to ascertain whether pressure adjustments are needed; or
- **C.** When clinical response is insufficient or when symptoms return despite a good initial response to treatment with CPAP.

IV. WellCare of North Carolina® **Shall Not** cover sleep studies and polysomnography for the following indications:

- **A.** Impotence.
- **B.** Chronic insomnia, except when an underlying physiology exists, such as those listed under **Criteria I**.
- **C.** Snoring, except when an underlying physiology exists, such as:
  1. Disturbed sleep patterns;
  2. Excessive daytime sleepiness;
  3. Unexplained awake hypercapnia;
  4. Apneic breathing;
  5. Cognitive problems; or
  6. Excessive fatigue.

V. WellCare of North Carolina® **Shall Not** cover Unattended (unsupervised) Sleep Studies or Home Sleep Tests (HST) for the following indications:

A. For a Member who is considered at low to moderate risk for OSA; or
B. After a negative, inconclusive, or technically inadequate HST; or
C. For a Member under 18 years of age.

VI. WellCare of North Carolina® **Shall Not** cover Home Sleep Tests (HST) for patients with certain medical comorbidities, including:

A. Moderate to severe pulmonary disease (e.g., patients on oxygen or regular bronchodilator use)
B. Neuromuscular disease affecting muscles of respiration
C. Congestive heart failure
D. Suspicion of the presence of other sleep disorders, i.e., narcolepsy, parasomnia, or periodic limb movements of sleep
E. Other respiratory disorders, impotence, restless legs syndrome
F. History of stroke
G. Chronic opioid medication use

VII. Requirements for and Limitations on Coverage

A. Previous Testing
Previous testing performed by the attending physician, to the extent the results are still pertinent, must not be duplicated.

B. General Requirements
Sleep studies and polysomnography must consist of recording, interpretation, and reporting.

C. Polysomnography Requirements
For a study to be reported as polysomnography, sleep must be recorded and staged. Sleep staging includes, but is not limited to:

1. 1- to 4-lead electroencephalogram (EEG);
2. Electro-oculogram (EOG);
3. Submental electromyogram (EMG);
4. Electrocardiogram (EKG);
5. Airflow, ventilation, and respiratory effort;
6. Oximetry and/or CO2 measurements;
7. Extremity muscle activity;
8. Extended EEG monitoring;
9. Gastroesophageal reflux;
10. Continuous blood pressure monitoring;
11. Habitual Snoring; or
12. Body positions.

VIII. Provider Qualifications and Occupational Licensing Entity Regulations
Service must be provided by a physician who meets all eligibility qualifications for participation in Criteria VIII, and meet the following:

A. The qualifications of the physician who interprets and bills the unattended sleep studies must include at least ONE of the following:
1. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM);
2. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS);
3. Completed residency or fellowship training by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or
4. Active staff membership of an accredited sleep center or laboratory.

IX. Documentation

In order to perform the technical component (TC) of PSG and sleep testing (including HST), the following must be met:

A. The sleep center or laboratory must maintain documentation on file that indicates it is accredited by either:
1. The American Academy of Sleep Medicine (AASM);
2. The Accreditation Commission for Health Care (ACHC); or
3. The Ambulatory Care Accreditation Program of the Joint Commission;

Background[1]

I. Definitions

A. Chronic Insomnia

Chronic insomnia, or long-term insomnia, is defined as a person having difficulty sleeping at least three nights a week for one month or longer.

B. Home Sleep Test (HST) or Unattended Sleep Study

Sleep testing is performed using unattended portable monitors for the diagnosis of obstructive sleep apnea. Home sleep testing is also called an Unattended Sleep Study, as a technologist is not present.

C. Hypoventilation

Hypoventilation is defined as a potentially lethal condition involving decreased ventilation associated with an increase in CO2 levels and possibly hypoxemia.

D. Maintenance of Wakefulness Test

The Maintenance of Wakefulness Test (MWT) means a test used to measure alertness during the day. It shows whether or not someone is able to stay awake for a defined period of time. This is an indicator of their ability to function and remain alert in quiet times of inactivity. It involves multiple trials throughout a day of low-demand activity when the instructions are to resist sleep.

E. Multiple Sleep Latency Test

The Multiple Sleep Latency Test (MSLT) means a test that measures excessive daytime sleepiness by determining how quickly someone can fall asleep in a quiet environment during the day. Also known as a daytime nap study, the MSLT is the standard tool used to diagnose narcolepsy and idiopathic hypersomnia.

F. Narcolepsy and Idiopathic Hypersomnolence

Narcolepsy and idiopathic hypersomnolence are defined as syndromes characterized by abnormal sleep tendencies. Symptoms are:

1. Inappropriate sleep episodes or attacks (while driving, in the middle of a meal, in the middle of a conversation); and
2. Amnesiac episodes, or continuous disabling drowsiness.

G. Obstructive Sleep Apnea (OSA)

OSA means a potentially serious disorder in which breathing repeatedly stops and starts during sleep. There are several types of sleep apnea, but the most common is obstructive sleep apnea. (OSA) may be caused by any ONE of the following:

1. Reduced upper airway caliber due to obesity;
2. Adeno-tonsillar hypertrophy (unusual growth of the adenoid);
3. Mandibular deficiency;
4. Macroglossia (unusually large tongue);
5. Upper airway tumor;
6. Excessive pressure across the collapsible segment of the upper airway; or
7. Activity of the muscles of the upper airway insufficient to maintain patency.

H. Parasomnia

Parasomnia means a group of conditions that represent undesirable or unpleasant occurrences during sleep. These conditions are:

1. Sleepwalking;
2. Sleep terrors and nightmares;
3. Rapid eye movement (REM) sleep behavior disorders;
4. Confusional arousals; or
5. Recurrent isolated sleep paralysis.

Suspected seizure disorders as possible cause of the parasomnia are appropriately evaluated by standard or prolonged sleep EEG (Electroencephalogram) studies. A Member shall undergo polysomnography in a sleep laboratory when they are at risk for harming themselves or others or have symptoms referable to other sleep disorders.

I. Periodic Limb Movement Disorder (PLMD)

PLMD means an involuntary, repetitive movement disorder during sleep, primarily in the legs that may lead to arousals, sleep disruption, and corresponding daytime sleepiness.

J. Sleep Apnea
Sleep apnea means a potentially lethal condition where the Member stops breathing during sleep. The three types are:
1. Central (absence of respiratory effort),
2. Obstructive (occlusion of the airway), and
3. Mixed (combination of these factors).

K. Apnea
Apnea means a cessation of airflow for at least ten seconds.

L. Hypopnea
Hypopnea means an abnormal respiratory event lasting at least ten seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow with at least four percent oxygen desaturations.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

CPT®* Codes	Description
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Billing Units

The provider shall report the appropriate procedure code(s) used which determines the billing unit(s).

A. **Polysomnography and sleep studies** may be billed as a complete procedure or as professional and technical components.

1. Polysomnography and sleep studies are limited to one procedure per date of service by the same or different provider.
2. The technical or the professional component cannot be billed by the same or different provider on the same date of service as the complete procedure is billed.
3. The complete procedure is viewed as an episode of care that may start on one day and conclude on the next day. When billing for the complete procedure, the date that the procedure began is the date of service that must be billed. The complete procedure must not be billed with two dates of service.
4. If components are billed, the technical and the professional components must be billed with the date the service was rendered as the date of service.

B. **Separate reimbursement** is not allowed for the following procedures on the same date of service by the same or different provider:

1. Electrocardiographic monitoring for 24 hours (CPT codes 93224 through 93272) with sleep studies and polysomnography (CPT codes 95800 through 95811).
2. Non-invasive ear or pulse oximetry single or multiple determinations (CPT codes 94760 and 94761) with sleep studies and polysomnography (CPT codes 95800 through 95811).
3. Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour, continuous recording, infant, (CPT code 94772) with sleep studies (CPT codes 95800 through 95806) (age six and under).
4. Continuous positive airway pressure ventilation, CPAP, initiation and management, (CPT code 94660) with polysomnography (CPT code 95800 through 95811).
5. Electroencephalogram (CPT codes 95812 through 95827) with polysomnography (CPT codes 95800 through 95811).
6. Facial nerve function studies (CPT code 92516) with polysomnography (CPT codes 95800 through 95811).

Place of Service
Inpatient hospital, Outpatient hospital, Physician's office, Independent Diagnostic Treatment Facility (IDTF), home.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	08/23	08/23
Annual Review. Changed 'beneficiary' to 'member.' Removed the 'Medicaid and health choice' verbiage from the References.	08/24	08/24

References

1. State of North Carolina Medicaid Clinical Coverage Policy No:1A-20 Sleep Studies and Polysomnography Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published December 15, 2023. Accessed June 6, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay

the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.