

MEDICAL POLICY

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Product Disclaimer	<ul style="list-style-type: none"> • <i>Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.</i> • <i>If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.</i> • <i>If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.</i> • <i>If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.</i> • <i>If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.</i>

POLICY STATEMENT

I. Polysomnography (PSG)

- A. Based upon our criteria and assessment of the peer-reviewed literature, a facility-based polysomnography (PSG) is the standard diagnostic test for sleep disorders and, therefore, is considered **medically appropriate** for the evaluation of sleep disorders when performed for **ANY** of the following indications:
1. to diagnose sleep-related breathing disorders when home sleep testing is negative, inconclusive, or technologically inadequate, or otherwise not a covered benefit;
 2. to assess the quality and quantity of night-time sleep in a patient with suspected narcolepsy or hypersomnia (PSG is performed the night prior to the Multiple Sleep Latency Test (MSLT));
 3. to diagnose sleep-related disorders in infants and children under 18 years of age whose medical records document one or more of the following:
 - a. observations of gross or subtle snoring, cessation in breathing, difficulty breathing, and sleep disturbances. Snoring may be of a continuous nature, rather than periodic as in adults; or
 - b. symptoms associated with cardio-pulmonary, growth, behavior and/or developmental problems that are suspected to be caused by upper airway obstruction.
- B. Based upon our criteria and assessment of the peer-reviewed literature, PSG has been medically proven to be effective and, therefore, is considered **medically appropriate** for the evaluation of sleep disorders when performed for patients with **ANY** of the following indications, if diagnostic questions remain after completion of the standard evaluation, when treatment decisions will be made based on the results of the study, and when the symptoms are of a severity to place the individual at risk for serious complications or injury:
1. neuromuscular disorders and sleep-related symptoms;

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2. paroxysmal arousals or other sleep disturbances thought to be seizure-related;
 3. sleep-related epilepsy that does not respond to conventional therapy;
 4. unexplained hypersomnolence;
 5. complicated/injurious parasomnias;
 6. periodic limb movement disorder;
 7. central nervous system (CNS) hypoventilation;
 8. chronic opioid medication misuse or abuse, including for patients on a methadone maintenance program or a chronic pain treatment program;
 9. recent stroke or myocardial infarction (MI) within the last six months;
 10. moderate or severe congestive heart failure (CHF) (NYHA Class III or IV);
 11. moderate (FEV1 between 50% and 80% of normal) or severe (FEV1 between 30% and 50% of normal) chronic obstructive pulmonary disease (COPD) with hypercapnia or hypoxemia;
 12. congenital syndromes (e.g., spina bifida) in an adult;
 13. cognitive deficits making understanding of instructions difficult;
 14. limb extremity impediments (missing or non-functioning);
 15. BMI greater than or equal to 45 kg/m²;
 16. drainage tubes in abdomen (e.g., post operative colostomy/urostomy);
 17. significant arrhythmias (not including atrial fibrillation);
 18. burns or wounds affecting significant portion of the abdomen;
 19. language barrier, where attempts to give instructions are unavailable or have failed;
 20. group home resident; elderly or disabled person;
 21. infant or child being considered for removal of a tracheostomy;
 22. infant or child with suspected congenital central alveolar hypoventilation syndrome or sleep-related hypoventilation due to neuromuscular disorders or chest wall deformities; or
 23. child being considered for adenotonsillectomy to treat obstructive sleep apnea (OSA) syndrome.
- C. Based upon our criteria and assessment of the peer-reviewed literature, PSG does not improve patient outcomes and, therefore, is considered **not medically necessary** for the following indications:
1. diagnosis of chronic lung disease;
 2. cases of typical uncomplicated and non-injurious parasomnias (e.g., somnambulism, pavor nocturnus, or nocturnal seizures) when the diagnosis is clearly delineated;
 3. epilepsy in patients who have no specific complaints consistent with a sleep disorder;
 4. diagnosis or treatment of restless leg syndrome, except where uncertainty exists in the diagnosis;
 5. diagnosis of circadian rhythm sleep disorders;
 6. diagnosis of depression;
 7. determining risk of sudden infant death syndrome (SIDS);
 8. diagnosis of bruxism (grinding of teeth);
 9. diagnosis of drug dependency;
 10. insomnia (inability to sleep);
 11. night terrors/dream anxiety;
 12. migraine headaches;
 13. male impotence, unless:
 - a. a nocturnal penile tumescence test is positive, or
 - b. brachiopenile impotence is suspected; or
 14. evaluation of for medication-related (titration) sleep stage effects.

II. Follow-up/ Repeat Polysomnography

Based upon our criteria and assessment of the peer-reviewed literature, follow-up PSG is considered **medically appropriate** in the following circumstances:

- A. when a prior, medically necessary PSG that was appropriately prepared and performed was inadequate/not diagnostic due to limited sleep time or other variable (not an inconclusive or negative exam);
- B. for the re-evaluation of a patient diagnosed with OSA with adequate treatment and persistent symptoms;
- C. for a patient with a current OSA diagnosis who is seeking to discontinue positive airway pressure (PAP/CPAP/APAP) therapy (e.g., as a result of expected symptom improvement after treatment);

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- D. to assess treatment response after surgical intervention for OSA or after initiation of an oral appliance to ensure therapeutic benefit;
 - 1. polysomnography after hypoglossal nerve stimulation implant will require follow up polysomnography specially related to titration of device.
- E. after a substantial weight loss (10% of body weight) to determine whether CPAP is still needed at the previously titrated pressures;
- F. after a substantial weight gain (10% of body weight) in a patient who has been treated successfully with CPAP/APAP and whose symptoms have returned, to assess whether pressure adjustments are needed; or
- G. to re-evaluate a pediatric patient diagnosed with OSA who:
 - 1. after adequate treatment with tonsillectomy and/or adenoidectomy or compliance with PAP therapy and has continued signs and symptoms of OSA (including disturbed or restless sleep); or
 - 2. has a high risk of having persistent OSA after tonsillectomy or adenoidectomy.

III. Split-Night Study

Based upon our criteria and assessment of the peer-reviewed literature, a split-night study for diagnosis and treatment is considered **medically appropriate** when criteria for PSG are met (*refer to Policy Statement I and/or IV*).

IV. CPAP Titration

- A. Based upon our criteria and assessment of the peer-reviewed literature, a facility-based CPAP titration study is considered **medically appropriate** when criteria for PSG are met (*refer to Policy Statement I*) and the patient has been diagnosed with **ANY** of the following:
 - 1. co-morbid conditions (e.g., COPD, asthma, documented neuromuscular disease, CHF with left ventricular ejection fraction (LVEF) less than 45%, cognitive impairment) and positive diagnosis of OSA;
 - 2. central sleep apnea; (e.g., central hypopnea/apnea greater than 50% of the total apnea hypopnea rate, or central hypopnea/apnea rate/index greater than five events per hour);
 - 3. mixed sleep apnea;
 - 4. significant hypoxemia defined as oxygen saturation less than or equal to 88% for a minimum of five continuous minutes during a two-hour diagnostic time period; or
 - 5. oxygen deficiency requiring supplemental oxygen.
- B. A facility-based CPAP titration study that does not meet criteria for a facility-based PSG and the criteria listed above (A.1 through A.5) is considered **not medically necessary**. A home PAP study may be appropriate.

V. Multiple Sleep Latency Test (MSLT)

- A. Based upon our criteria and assessment of the peer-reviewed literature, an initial MSLT is considered **medically appropriate** as a diagnostic tool when **ALL** of the following are met:
 - 1. The patient is suspected of having narcolepsy or idiopathic hypersomnia, as evidenced by one of the following criteria being met:
 - a. Excessive sleepiness;
 - b. Recurrent daytime naps or lapses into sleep daily for at least three months;
 - c. Cataplexy – the sudden loss of muscle tone occurring in association with intense emotion (e.g., laughing or crying);
 - d. Sleep paralysis, hypnagogic hallucinations, hypnopompic hallucinations, automatic behaviors, or disrupted major sleep episodes; or
 - e. Idiopathic hypersomnia;
 - AND**
 - 2. The MSLT immediately follows a PSG that was negative for OSA, where total sleep time is greater than six hours (however, it should not follow a split-night study);
 - AND**
 - 3. The patient has not used stimulants, stimulant-like medications, sedatives, or REM-suppressing medications for two weeks prior to the test or negative results on urine drug testing immediately preceding within a day of the study;
 - AND**

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4. A comprehensive sleep evaluation, including established sleep disorder tools and/or questionnaires has been performed;

AND

5. If OSA is suspected, a diagnostic study has been performed;

OR

6. If OSA is present, therapy has been initiated and has resolved the patient's symptoms.

B. Repeat testing may be necessary when initial MSLT results are negative, ambiguous, or did not provide polygraphic confirmation after a properly performed test and the clinical history strongly indicates a diagnosis of narcolepsy or idiopathic hypersomnia's or when the response to treatment must be ascertained.

VI. Nocturnal Pulse Oximetry

A. Based upon our criteria and assessment of the peer-reviewed literature, nocturnal pulse oximetry is considered **medically appropriate** for follow-up studies, when a diagnosis has been established by standard polysomnography, CPAP, BiPAP, or APAP; or oxygen therapy has been initiated; and when ordered by a pulmonologist or sleep medicine specialist. The intent is most often to evaluate response to therapy.

B. Based upon our criteria and assessment of the peer-reviewed literature, nocturnal pulse oximetry is considered **not medically necessary** as a diagnostic tool for any other OSA indication. However, nocturnal pulse oximetry is indicated when determining the proper oxygen dose for patients with chronic pulmonary disease.

VII. EEG Topography

Based upon our criteria and assessment of the peer-reviewed literature, when used for the diagnosis and/or medical management of OSA syndrome, EEG topography has not demonstrated a benefit to patient outcomes and, therefore, is considered **investigational**.

VIII. Actigraphy

A. Based upon our criteria and assessment of the peer-reviewed literature, actigraphy is considered **medically appropriate** in children aged four to 18 years, who have insomnia and/or circadian rhythm disorder associated with excessive daytime sleepiness, where there is a discrepancy between reported sleep history and described symptoms. Only one actigraphy study per year is allowed.

B. Based upon our criteria and assessment of the peer-reviewed literature, actigraphy is considered **investigational** for all other indications.

C. Wrist actigraphy requires a minimum of 14 days' recording, with interpretation of report and results generated. Commercial fitness trackers (e.g., Fitbit) are ineligible for coverage,

IX. PAP-Nap

Based upon our criteria and the lack of peer-reviewed literature, PAP-Nap is considered **investigational**.

X. Pharyngometer and Rhinometer Testing

Based upon our criteria and assessment of the peer-reviewed literature, acoustic pharyngometry (e.g., Eccovision Acoustic Pharyngometer), versions of the SNaP Testing System using fewer than three channels, rhinomanometry, acoustic rhinometry, and optical rhinometry are considered **investigational** for screening, diagnosis, or treatment planning in persons with suspected or known OSA and for all other indications.

Refer to Corporate Medical Policy #1.01.06 Positive Airway Pressure Devices

Refer to Corporate Medical Policy #1.01.07 Oral Appliances for the Treatment of Sleep-Related Breathing Disorders

Refer to Corporate Medical Policy #7.01.41 Surgical Management of Sleep Disorders

Refer to Corporate Medical Policy #11.01.03 Experimental and Investigational Services

POLICY GUIDELINES

I. Coverage for sleep studies for the evaluation of sleep disorders, as well as prior authorization, is contract dependent. Please refer to your Customer (Member/Provider) Service Department for determination of contract benefits.

II. The probability of OSA is determined via a comprehensive sleep evaluation by a sleep specialist. Established sleep disorder tools and questionnaires (e.g., Epworth Sleepiness Scale; Berlin questionnaire, Wisconsin questionnaire,

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STOP, and STOP-BANG questionnaires) may assist the specialist in the evaluation of a patient with a suspected sleep disorder.

A patient with a high pre-test probability of moderate to severe obstructive sleep apnea may exhibit the following signs and symptoms, which have been persistent for greater than four weeks in duration:

- A. Patient has reported excessive sleepiness or non-restorative, disturbed, or restless sleep **AND** apneas, gasping, or choking at night has been witnessed, or
 - B. Patient has reported excessive sleepiness or non-restorative, disturbed, or restless sleep **AND** has **at least two** of the following supporting signs, symptoms, or risk factors:
 1. neck circumference greater than or equal to 17 inches for males or 16 inches for females;
 2. obesity (BMI greater than 30);
 3. physiologic abnormalities compromising respiration (e.g., retrognathia, tonsillar hypertrophy);
 4. regularly observed disruptive snoring;
 5. refractory hypertension;
 6. morning headaches;
 7. decreased concentration;
 8. memory loss;
 9. decreased libido;
 10. irritability; or
 11. nocturia; or
 - C. Patient has unexplained documented pulmonary hypertension; or
 - D. Patient has unexplained polycythemia with Hg greater than 18.5 g/dL in males or 16.5 g/dL in females.
 - E. In addition, pediatric patients, aged six years or less, may exhibit the following symptoms:
 1. neurobehavioral problems including attention deficit hyperactivity disorder;
 2. failure to thrive;
 3. neuromuscular disorders;
 4. paradoxical breathing;
 5. nocturnal diaphoresis;
 6. secondary enuresis; or
 7. persistent symptoms present for greater than four weeks in duration not only associated with respiratory infections.
- III. The testing facility must be a sleep disorder center. A sleep disorder center is a medical facility providing clinical diagnostic services and treatment to patients who present with symptoms or features that suggest the presence of a sleep disorder.
- IV. The American Academy of Sleep Medicine must accredit all sleep disorder centers, for coverage of the services to be considered.
- V. Sleep studies should be interpreted by a physician who meets any of the following criteria:
- A. Certified by the American Board of Sleep Medicine (ABSM);
 - B. Holds subspecialty certification in sleep medicine by a member board of the American Board of Medical Specialties (ABMS), such as the American Board of Family Medicine, the American Board of Internal Medicine, the American Board of Otolaryngology, the American Board of Pediatrics, or the American Board of Psychiatry and Neurology;
 - C. Has completed a residency in sleep medicine and meets the Health Plan's credentialing criteria for board certification; or
 - D. Is an active staff member of a sleep disorder center certified by the American Academy of Sleep Medicine.
- VI. An unattended, cardiorespiratory sleep study (Type III device) may be an acceptable alternative to full night PSG for those patients with a high-pretest probability of OSA who are without significant comorbid conditions. A full PSG may be required for those symptomatic patients who have a negative cardiorespiratory home sleep study.

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VII. A home/portable sleep study (HST) is an alternative to a facility-based PSG for patients who do not meet criteria in Policy Statement I A-C.

DESCRIPTION

Sleep disorders medicine is a clinical specialty concerned with diagnosis and treatment of patients with disorders of sleep and daytime alertness. Categories of sleep disorders include:

- I. Insomnia. Insomnia is a persistent difficulty with sleep initiation, duration, consolidation, or quality that occurs despite adequate opportunity and circumstances for sleep, and results in daytime impairment. Among adults with insomnia, sleep complaints most typically include difficulties initiating or maintaining sleep. Concerns about lengthy periods of nocturnal wakefulness, insufficient amounts of nocturnal sleep, or poor sleep quality often accompany these complaints. Insomnia among children is often reported by their caretakers and characterized by bedtime resistance, frequent nighttime awakenings and/or an inability to sleep independently. Regardless of the exact nature of the nocturnal sleep concerns, daytime impairments are reported, presumably caused by the nighttime sleep difficulties or by some common but unidentified mechanism during sleep and wakefulness. Daytime symptoms typically include fatigue, decreased mood or irritability, general malaise, and cognitive impairment.
- II. Sleep related breathing disorders. Sleep related breathing disorders are characterized by abnormalities of respiration during sleep. In some of these disorders, respiration is also abnormal during wakefulness. The disorders are grouped into OSA disorders, central sleep apnea disorders, sleep related hypoventilation disorders, and sleep-related hypoxemia disorder. However, many patients will meet diagnostic criteria for more than one of these groups. In particular, many patients have a combination of obstructive and central sleep apnea. Although a diagnosis is often based on which disorder predominates, this may vary from night to night, as well as over time, in individual patients. There is also overlap in pathophysiology, as some central apneas are associated with a closed upper airway and many obstructive apneas begin during a time of falling ventilatory drive.
- III. Central disorders of hypersomnolence. Central disorders of hypersomnolence includes a group of disorders in which the primary complaint is daytime sleepiness not caused by disturbed nocturnal sleep or misaligned circadian rhythms. Other sleep disorders may be present, but they must be adequately treated before a diagnosis in this category can be established. The term “hypersomnolence” is used to describe the symptom of excessive sleepiness, whereas “hypersomnia” refers to specific disorders, such as idiopathic hypersomnia.
- IV. Circadian rhythm sleep-wake disorders. Circadian rhythm sleep-wake disorders (CRSWDs) are disorders that are caused by alterations of the circadian time-keeping system or its entrainment mechanisms, or a misalignment of the endogenous circadian rhythm and the external environment. Most CRSWDs arise when a substantial misalignment exists between the internal rhythm and the required timing of the patient's school, work, or social activities. The most common presenting symptoms of CRSWDs are difficulty initiating and maintaining sleep and excessive sleepiness, but their impact extends to adverse health outcomes; impairments in social, occupational, and educational performance; and safety concerns.
- V. Parasomnias. Parasomnias are undesirable physical events or experiences that occur during entry into sleep, within sleep, or during arousal from sleep. Parasomnias may occur during non-rapid eye movement sleep (NREM), rapid eye movement sleep (REM), or transitions to and from sleep. Parasomnias encompass abnormal, sleep-related, complex movements, behaviors, emotions, perceptions, dreams, and autonomic nervous system activity. Parasomnias are clinical disorders because of the resulting injuries, sleep disruption, adverse health effects, and untoward psychosocial effects. The clinical consequences of the parasomnias can affect the patient, the bed partner, or both.
- VI. Sleep related movement disorders. Sleep-related movement disorders are primarily characterized by simple, usually stereotyped, movements that disturb sleep or its onset. Restless leg syndrome (RLS) is an exception in that patients typically engage in walking or non-stereotypic limb movement to reduce leg discomfort. However, RLS is closely associated with periodic limb movements (PLMs), which are usually simple and stereotyped within a series. Nocturnal sleep disturbance or complaints of daytime sleepiness or fatigue are a prerequisite for a diagnosis of a sleep-related movement disorder. Body movements that disturb sleep also are seen in many other sleep disorder categories (e.g., parasomnias such as sleepwalking, sleep terrors, and REM sleep behavior disorder). However, these parasomnias differ from the simple stereotyped movements categorized as sleep-related movement disorders in that

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they involve complex behaviors during the sleep period. Parasomnia-related movements may appear purposeful and goal-directed, but are outside the conscious awareness of the individual. Parasomnias are listed in a separate section from the sleep-related movement disorders.

TYPES OF SLEEP TESTING

A polysomnography, or PSG, refers to any one of a class of tests that utilizing continuous polygraph recording, usually over the course of a night, of electrophysiological measurements relevant to diagnosing sleep disorders. The four components of a PSG include: (1) electrographic recordings (EKG, EMG, EEG, EOG); (2) ventilatory variables that permit the identification of apneas and their classification as central or obstructive; (3) arterial oxygen saturation by finger oximetry; and (4) heart rate. In addition, a PSG may also include additional monitoring modalities such as esophageal monitoring and blood pressure monitoring. By definition, a PSG always requires sleep staging (EEG, EOG, and EMG). In contrast, an unattended cardiorespiratory sleep study does not include sleep staging. The components of any sleep test are dictated by the clinical situation. The number and nature of parameters studied depends upon the judgment of the sleep disorders medical specialist. The terms “sleep studies” and “polysomnogram” are often used interchangeably. However, CPT and HCPCS coding makes the distinction between the two in the following way: polysomnography includes EEG monitoring, while unattended cardiorespiratory sleep studies do not.

Split-night sleep studies utilize the final portion of the overnight PSG to titrate CPAP. A split-night sleep study is an alternative to a full night of diagnostic PSG followed by a second night of CPAP titration.

Multiple Sleep Latency Test (MSLT) is performed the day after overnight PSG is completed. MSLT utilizes the same parameters as a basic polysomnogram for sleep staging (e.g., EEG, EKG, EMG, EOG). It measures mean sleep latency (MSL), calculated by the average time elapsed from the start of daytime nap periods to the onset of sleep. The standardized MSLT is conducted with four or five nap attempts during a single day, which are each separated by two hours. Each nap attempt is ended if the subject fails to fall asleep within 20 minutes. An MSL of eight minutes or less and two or more sleep onset REM periods on the MSLT is indicative of a pathological state called narcolepsy (Iskander et al., 2023).

Pharyngometer and rhinometer testing, the pharyngometer graphically displays the relationship between the cross-sectional area of the airway and the distance down the airway in centimeters. The rhinometer uses acoustic reflection to map out the cross-sectional area measurements into the nasal airway.

EEG Topography is a computer based electroencephalographic mapping of the spatial distributions of pre-defined frequency bands.

Nocturnal pulse oximetry is the measurement of oxygen saturation, usually overnight, in the home. It is utilized for several clinical purposes such as evaluating patients for obstructive sleep apnea and for determining oxygen dosing in patients with chronic pulmonary disease.

Actigraphy consists of a small portable device, usually worn on the wrist or ankle, that senses physical motion and stores that information for future displaying, scoring, and interpretation. Recordings can be conducted for days or weeks on patients in their own homes. Actigraphy has been used by researchers to measure sleep disturbances reflective of a variety of clinical sleep disorders, including insomnias, hypersomnia, circadian rhythm disorders, and PLM disorders.

PAP-Nap (Positive Airway Pressure Nap) is an abbreviated daytime sleep evaluation that has been proposed as a method of assessing, addressing and alleviating physical, mental, and emotional barriers in patients who may benefit from PAP therapy. PAP-NAPs include mask and pressure desensitization, emotion-focused therapy to overcome aversive emotional reactions, mental imagery to divert patient attention from mask or pressure sensations, and physiological exposure to PAP therapy during a 100-minute nap period. The primary goal of PAP-Nap is to help patients use PAP therapy for more than one hour, during which they have the potential to fall asleep with the mask in place or at least report that the experience was comfortable. PAP-Nap is not a titration but instead provides the patient with physiologic exposure to PAP therapy as well as to the lab environment. It does not provide definitive sleep or breathing evaluations.

The American Academy of Sleep Medicine (AASM) issued recommendation in 2017 that were intended as a guide for clinicians diagnosing OSA in adults. A **STRONG** recommendation was one that clinicians should follow under most circumstances. A **WEAK** recommendation reflected a lower degree of certainty regarding the outcome and

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appropriateness of the patient-care strategy for all patients. The AASM indicated that the ultimate judgment regarding the propriety of any specific care must be made by the clinician in light of the individual circumstances presented by the patient, available diagnostic tools, accessible treatment options, and resources.

The AASM considered the following to be good practice statements:

- Diagnostic testing for OSA should be performed in conjunction with a comprehensive sleep evaluation and adequate follow-up.
- Polysomnography is the standard diagnostic test for the diagnosis of OSA in adult patients in whom there is a concern for OSA based on a comprehensive sleep evaluation.

The AASM 2017 recommendations:

1. Clinical tools, questionnaires and prediction algorithms should not be used to diagnose OSA in adults, in the absence of polysomnography or home sleep apnea testing. (STRONG)
2. Polysomnography, or home sleep apnea testing with a technically adequate device, should be used for the diagnosis of OSA in uncomplicated adult patients presenting with signs and symptoms that indicate an increased risk of moderate-to-severe OSA. (STRONG)
3. If a single home sleep apnea test is negative, inconclusive, or technically inadequate, polysomnography should be performed for the diagnosis of OSA. (STRONG)
4. Polysomnography, rather than home sleep apnea testing, should be used for the diagnosis of OSA in patients with significant cardiorespiratory disease, potential respiratory muscle weakness due to neuromuscular condition, awake hypoventilation or suspicion of sleep-related hypoventilation, chronic opioid medication use, history of stroke or severe insomnia. (STRONG)
5. If clinically appropriate, a split-night diagnostic protocol, rather than a full-night diagnostic protocol for polysomnography should be used for the diagnosis of OSA. (WEAK)
6. When the initial polysomnogram is negative and clinical suspicion for OSA remains, a second polysomnogram should be considered for the diagnosis of OSA. (WEAK)

The AASM Position Statement for the Use of Home Sleep Apnea Test (HSAT) for Diagnosis of OSA in Children states that the use of a home sleep apnea test is not recommended for the diagnosis of OSA in children.

RATIONALE

Overnight PSG is an established diagnostic procedure used in conjunction with clinical examination in determining the presence and extent of OSA. PSG is considered the “gold standard” of OSA diagnosis and follow-up. It provides objective data on the type and severity of sleep-disordered breathing.

Pulse oximetry, when used alone, has not shown to have an adequate negative predictive value to rule out OSA (all patients with symptoms of OSA would require PSG regardless of whether pulse oximetry was negative or positive). Overnight oximetry has not been demonstrated to be a sufficiently reliable predictor of the presence of OSA, particularly mild OSA.

Actigraphy has been used in many research studies for the evaluation of rest-activity cycles. This technique has not been validated as a method of diagnosing OSA. The major limitation of the methodology is precision, as well as the lack of correlation between physical movement and sleep architecture. The role of actigraphy in clinical management of OSA is not clear, but it can be helpful in determining the length of time in bed and activity levels. Actigraphy studies show that it is not a sufficiently accurate substitute measure for sleep time, to recommend for routine use. The default actigraphy settings may not be optimal for people with COPD and coexisting insomnia. The AASM (2018) considered the use of actigraphy “conditional” (low degree of certainty of the outcome and appropriateness of the patient-care strategy) for all indications including insomnia (adult and pediatric) and circadian rhythm sleep-wake disorder, and to estimate or monitor total sleep time for patients with sleep-disordered breathing. The AASM indicated that actigraphy should not be used in place of electromyography for the diagnosis of periodic limb movement (PLM) disorder in either adults or pediatric patients.

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MSLT is a validated, objective measure of the tendency to fall asleep and the ability to stay awake for a defined time, respectively. Studies of the MSLT procedure demonstrate significant differences in mean sleep latency values between healthy subjects and patients with excessive sleepiness due to narcolepsy or idiopathic hypersomnia.

There is insufficient evidence in the published medical literature to determine whether PAP-Nap studies result in improved adherence to therapy or improved patient outcomes.

The diagnosis of PLM disorder requires quantification of PLMs and PLM-related arousals, assessment of the impact of the movements upon sleep architecture, and identification and exclusion of other sleep disorders. Although PLM disorder can exist independent of restless leg syndrome (RLS), it is estimated that over 80% of individuals with RLS have evidence of PLM on PSG, so PSG may be helpful in increasing the confidence in the RLS diagnosis.

Pharyngometer and rhinometer testing for screening, diagnosis, or treatment planning in persons with suspected or known OSA and for all other indications lacks clinical studies demonstrating that these tests improve clinical outcomes, and their effectiveness has not been established. The methods that detect structural and functional abnormalities of the upper airway implicated as risk factors for OSA continue to stimulate interest, because it is hoped that they may allow physicians to distinguish patients more easily with OSA from those without it, and, thereby, reduce the number of unnecessary sleep studies. The evidence of efficacy necessary to support the correlation between test results and OSA diagnosis is lacking.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
92512 (E/I)	Nasal function studies (e.g., rhinomanometry)
92520 (E/I)	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
94762	Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring (separate procedure)
95782	Polysomnography; younger than 6 years, sleep staging with four (4) or more additional parameters of sleep, attended by a technologist
95783	Polysomnography; younger than 6 years, sleep staging with four (4) or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone) and sleep time
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

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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. Please note: 95807 with modifier 52 (reduced service) may be billed for a PAP-NAP and is considered E/I.
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 four (4) or more additional parameters of sleep, attended by a technologist
95811	Polysomnography; age 6 years or older, sleep staging with four (4) or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

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Code	Description
No specific codes	

ICD10 Codes

Code	Description
F51.8	Other sleep disorders not due to a substance or known physiological condition
G40.001- G40.219	Localization-related (focal) (partial) idiopathic of symptomatic epilepsy and epileptic syndromes (code range)
G40.301- G40.319	Generalized idiopathic epilepsy and epileptic syndromes (code range)
G40.401- G40.419	Other generalized epilepsy and epileptic syndromes (code range)
G40.501- G40.509	Epileptic seizures related to external causes (code range)
G40.801- G40.804	Other epilepsy (code range)
G40.811- G40.814	Lennox-Gastaut syndrome (code range)
G40.821- G40.824	Epileptic spasms (code range)
G40.89	Other seizures
G40.901- G40.919	Epilepsy, unspecified (code range)
G40.A01- G40.A19	Absence epileptic syndrome (code range)

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Code	Description
G40.B01- G40.B19	Juvenile myoclonic epilepsy (code range)
G47.00	Insomnia, unspecified
G47.10	Hypersomnia, unspecified
G47.20	Circadian rhythm sleep disorder, unspecified type
G47.30	Sleep apnea, unspecified
G47.411- G47.429	Narcolepsy (code range)
G47.8-G47.9	Other and unspecified sleep disorders (code range)
R56.9	Unspecified convulsions

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*Key Article

KEY WORDS

Actigraphy, EEG Topography, MSLT, PAP-Nap, Polysomnography, Sleep study.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) 240.4.1 that addresses Sleep Testing for Obstructive Sleep Apnea (OSA). Please refer to the following website for Medicare Members: [<https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=330&ncdver=1&bc=AAAAGAAAAAA&>] accessed 12/18/23.

There is currently a Local Coverage Determination L36839: [<https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=36839>] accessed 12/18/23.

There is a Medical Policy Article A53019 addressing Polysomnography and Sleep Studies describes sleep study credentialing and documentation requirements. Please refer to the following website for Medicare Members:

[https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=53019&ver=11&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=polysomnography&KeyWordLookUp=Title&KeyWordSearchType=And&NCDId=41&ncdver=1&ncd_id=30.1&ncd_version=1&basket=ncd%25253A30%25252E1%25253A1%25253ABiofeedback+Therapy&bc=gAAAACAAQAAA&] accessed 12/18/23.