Sleep studies

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

Administrative Process

Prior authorization is not required for home sleep studies, or for in-lab sleep studies at this time.

Coverage

Sleep studies are generally covered subject to the indications listed below and per your plan documents.

Indications that are covered

Home sleep studies are generally recommended as a first line diagnostic measure, when the results of a general evaluation indicate the member is suspected of having uncomplicated obstructive sleep apnea (OSA). If an in-lab sleep study / polysomnogram is required, then it is covered subject to the indications below.

Tests for Suspected Sleep Related Breathing Disorders (SRBDs) including but not limited to Obstructive Sleep Apnea (OSA) and Upper Airway Resistance Syndrome (UARS)

For adult members (age 18 & older):

Polysomnography (PSG)

1. Prior to the sleep study, member has a general evaluation which includes a thorough sleep history and physical examination. The evaluation should serve to establish a suspected diagnosis of SRBD, which can then be used to select the appropriate in-lab test(s).
2. Polysomnography is covered for members displaying one or more of the following symptoms or risk factors (A. – F.) for SRBD, and meeting either criterion 3, 4, 5, or 6.
   A. Excessive daytime somnolence; or
   B. Witnessed apneas; or
   C. Gasping or choking at night; or
   D. Disruptive snoring; or
   E. Increased neck circumference (i.e., > 17 inches in men, > 16 inches in women); or
   F. Obesity (i.e., body mass index $\geq 30$); and
3. Recent home/portal testing proved to be technically inadequate or failed to establish the diagnosis of OSA/UARS in an individual with high pretest likelihood of OSA/UARS; or
4. Individual and caregiver/companion are incapable of operating home testing equipment; or
5. Member is suspected of having central sleep apnea (CSA); or
6. Member has a significant comorbid condition that would be expected to degrade the accuracy of a home/ portable study, such as any of the following:
   A. Moderate to severe pulmonary disease, such as chronic obstructive pulmonary disease (COPD)
   B. Moderate to severe neuromuscular/neurodegenerative disorder causing restrictive lung diseases (e.g., amyotrophic lateral sclerosis (ALS), postpolio syndrome)
   C. Congestive heart failure (CHF) (moderate to severe)
   D. Obesity hypoventilation syndrome, previously documented
7. Polysomnography is covered as part of a preoperative clinical evaluation prior to undergoing upper airway surgery for snoring or obstructive sleep apnea.
8. Polysomnography is covered for members with systolic or diastolic heart failure if they have nocturnal symptoms suggestive of sleep related breathing disorders (disturbed sleep, nocturnal dyspnea, snoring) or if they remain symptomatic despite optimal medical management of congestive heart failure.

Follow-up Polysomnography

Follow-up polysomnography is routinely indicated for the assessment of treatment results in the following circumstances:

1. After good clinical response to oral appliance treatment in members with moderate to severe OSA, to ensure therapeutic benefit.
2. After surgical treatment of members with moderate to severe OSA, to ensure satisfactory response.
3. After surgical or dental treatment of members with SRBDs whose symptoms return despite a good initial response to treatment.
4. After substantial weight loss (e.g., 10% of body weight) has occurred in members on continuous positive airway pressure (CPAP) for treatment of SRBDs to ascertain whether CPAP is still needed at the previously titrated pressure.

5. After substantial weight gain (e.g., 10% of body weight) has occurred in members previously treated with CPAP successfully, who are again symptomatic despite the continued use of CPAP, to ascertain whether pressure adjustments are needed.

6. When clinical response is insufficient or when symptoms return despite a good initial response to treatment with CPAP. In these circumstances, testing should be devised with consideration that a concurrent sleep disorder may be present (e.g., OSA and narcolepsy).

**Positive Airway Pressure (PAP) Titration**

Polysomnography is indicated for positive airway pressure (PAP) titration in members with sleep related breathing disorders (SRBDs).

1. A full night PSG with CPAP titration is recommended for members with a documented diagnosis of a SRBD for whom PAP is warranted.

2. PSG with CPAP titration is appropriate for members with any of the following results:
   A. A respiratory disturbance index (RDI) of at least 15 per hour, regardless of the member’s symptoms.
   B. An RDI of at least 5 per hour in a member with excessive daytime sleepiness.

3. For CPAP titration, a split-night study (initial diagnostic PSG followed by CPAP titration during PSG on the same night) is an alternative to one full night of diagnostic PSG followed by a second night of titration if the following four criteria are met:
   A. An apnea-hypopnea index (AHI) of at least 40 is documented during a minimum of two hours of the diagnostic PSG. Split-night studies may sometimes be considered at an AHI of 20 to 40, based on clinical judgment (e.g., if there are also repetitive long obstructions and major desaturations). However, at AHI values below 40, determination of CPAP pressure requirements, based on split-night studies, may be less accurate than in full-night calibrations; and
   B. CPAP titration is carried out for more than 3 hours (because respiratory events can worsen as the night progresses); and
   C. The polysomnogram documents that CPAP eliminates or nearly eliminates the respiratory events during REM and non-REM (NREM) sleep, including REM sleep with the member in the supine position; and
   D. A second full night of PSG for CPAP titration is performed if the diagnosis of a SRBD is confirmed but criteria B. and C. are not met.

**Tests for other sleep disorders**

For adult members (age 18 & older):

**Narcolepsy**

Polysomnography and a multiple sleep latency test (MSLT) performed the day after the polysomnographic evaluation are routinely indicated in the evaluation of suspected narcolepsy to confirm the diagnosis. The MSLT is a validated objective measure of the ability or tendency to fall asleep.

1. To provide a valid assessment of sleepiness or wakefulness the MSLT must be performed under appropriate conditions using proper recording techniques and accepted protocols, with interpretation by a qualified and experienced clinician.

2. Coverage is limited to members with
   A. A history of excessive daytime sleepiness and/or cataplexy; or
   B. A previously identified sleep disorder such as obstructive sleep apnea syndrome or other sleep-related breathing disorder, periodic limb movement disorder, or mood disorder who continue to experience excessive sleepiness despite optimal treatment may require evaluation for possible narcolepsy, including the MSLT.

3. Repeat MSLT testing may be indicated in the following situations:
   A. When the initial test is affected by extraneous circumstances or when appropriate study conditions were not present during initial testing,
   B. When ambiguous or uninterpretable findings are present,
   C. When the member is suspected to have narcolepsy but earlier MSLT evaluation(s) did not provide polygraphic confirmation.

4. No alternatives to the polysomnogram and multiple sleep latency test have been validated for making the diagnosis of narcolepsy. Although the maintenance of wakefulness test (MWT) may be useful in assessing treatment adequacy (by measuring the ability to stay awake), it has not been shown to be as valid as the multiple sleep latency test (MSLT) for confirmation of excessive daytime sleepiness and the
Demonstration of sleep-onset REM periods.

Parasomnias
Common, uncomplicated, noninjurious parasomnias, such as typical disorders of arousal, nightmares, enuresis, sleepwalking, and bruxism, can usually be diagnosed by clinical evaluation alone.

1. Polysomnography is indicated when a diagnosis of periodic limb movement disorder (PLMD) is considered because of complaints by the member or an observer of repetitive limb movements during sleep and frequent awakenings, fragmented sleep, difficulty maintaining sleep, or excessive daytime sleepiness; and

2. The clinical history of member’s parasomnia must describe and characterize the behaviors in detail with special emphasis on age of onset, time of night, frequency, regularity, and duration of episodes.

Maintenance of Wakefulness Test (MWT)
The MWT is a validated objective measure of the ability to stay awake for a defined time. It is used in association with the clinical history to assess the ability to maintain wakefulness.

1. To provide a valid assessment of sleepiness or wakefulness the MWT must be performed under appropriate conditions using proper recording techniques and accepted protocols, with interpretation by a qualified and experienced clinician.

2. The MWT is indicated when excessive daytime sleepiness interferes with the performance of routine daily tasks and clinical features do not suggest a diagnosis of sleep apnea.

Pediatric Members (less than or equal to 18 years of age)
Polysomnography in children should be performed and interpreted in accordance with the recommendations of the American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events.

1. An in-lab sleep study / polysomnography is covered for pediatric members:

   A. When clinical assessment suggests the diagnosis of Obstructive Sleep Apnea Syndrome (OSAS).

   B. When positive airway pressure (PAP) titration is required for children with OSAS.

   C. After adenotonsillectomy which was performed for mild OSAS, when clinical evaluation indicates that residual symptoms of OSAS remain after surgery.

   D. To assess for residual OSAS following adenotonsillectomy in children who exhibited preoperative evidence of moderate to severe OSAS, obesity, craniofacial anomalies that obstruct the upper airway, or neurologic disorders (e.g., Down syndrome, Prader-Willi syndrome, and myelomeningocele).

   E. To diagnose suspected periodic limb movement disorder (PLMD).

   F. As part of the evaluation for suspected narcolepsy, followed by The MSLT, for children with a history of excessive daytime sleepiness and/or cataplexy.

   G. A polysomnogram using an expanded EEG montage is indicated in children to confirm the diagnosis of an atypical or potentially injurious parasomnia, or differentiate a parasomnia from sleep-related epilepsy when the initial clinical evaluation and standard EEG are inconclusive.

Indications that are not covered:

1. Polysomnography is not indicated to diagnose chronic lung disease.

2. Polysomnography is not routinely indicated for the diagnosis of circadian rhythm sleep disorders.

3. Polysomnography is not routinely indicated to diagnose or treat restless legs syndrome, except where uncertainty exists in the diagnosis.

4. Polysomnography is not routinely indicated for evaluation of children with sleep-related bruxism.

5. Polysomnography for the sole complaint of snoring is not covered.

6. Neither a polysomnogram nor a multiple sleep latency test (MSLT) is routinely indicated in establishing the diagnosis of depression.

7. The MSLT is not routinely indicated for most members with sleep related breathing disorders.

8. The MSLT is not routinely indicated for evaluation of sleepiness in medical and neurological disorders (other than narcolepsy), insomnia, or circadian rhythm disorders.

Definitions
Apnea-Hypopnea Index (AHI): the frequency of apneas and hypopneas per hour of sleep is expressed as the “apnea-hypopnea index” or the AHI (number of apneas plus hypopneas per hour of sleep).

Cataplexy: partial or total loss of muscle control, often triggered by strong emotion. Most commonly, persons with narcolepsy experience mild cataplectic attacks, where arm or leg muscles become weak, speech is slurred or their head droops. Sufferers remain fully conscious even during severe attacks. These attacks can occur randomly, but most often are brought on by any strong emotions. Laughter is reported as the most common stimulus.

Central Apnea: apnea is defined as a cessation of airflow for at least 10 seconds. The event is central if during apnea there is no effort to breathe.

ECG (electrocardiogram): a test which tracks and records heart rhythm.

EEG (electroencephalogram): a test which tracks and records brain wave patterns.

EMG (electromyography): a test which records muscle activity during sleep.

EOG (electrooculogram): a test which records the movements of the eyes during sleep and serves to help determine sleep stages.

Hypopnea: instance of abnormally slow or shallow breathing

Maintenance of Wakefulness Test (MWT): a test administered over the course of a day at a sleep laboratory which is used to measure how alert an individual is during the day, and whether they are capable of staying awake for a period of time in a quiet, relaxing, stimulation free environment. It consists of four trials performed at two hour intervals, with the first trial beginning about 1.5 to 3 hours after the member’s usual wake-up time. This usually equates to a first trial starting at 0900 or 1000 hours.

Mixed Apnea: Apnea is defined as a cessation of airflow for at least 10 seconds. The event is mixed if the apnea begins as a central apnea, but towards the end there is effort to breathe without airflow.

Multiple Sleep Latency Test (MSLT): a diagnostic test used to determine sleep disorders in which excessive daytime sleepiness is the primary complaint, such as narcolepsy and idiopathic hypersomnia. It is always a follow-up test to the overnight PSG which is used to rule out other sleep disorders. It consists of five nap opportunities each 20 minutes long and separated by 2 hours apart. The purpose of the tests are to determine how likely and quickly an individual falls asleep during the day in a relaxed and quiet environment. The initial nap opportunity begins 1.5 to 3 hours after termination of the nocturnal recording. A shorter four-nap test may be performed but this test is not reliable for the diagnosis of narcolepsy unless at least two sleep onset REM periods have occurred.

Obstructive Apnea: apnea is defined as a cessation of airflow for at least 10 seconds. The event is obstructive if during apnea there is effort to breathe.

Parasomnias: unusual or undesirable motor, behavioral and/or experiential events which occur during or in the transition to and from sleep.

Polysomnogram: a test which measures bodily functions during sleep and is done in-lab at a sleep center. It requires a minimum of the following recordings: EEG, EOG, chin EMG, airflow, arterial oxygen saturation, respiratory effort, and ECG or heart rate. Anterior tibialis EMG is useful to assist in detecting movement arousals and may have the added benefit of assessing periodic limb movements, which coexist with sleep related breathing disorders in many individuals.

Respiratory-Effort Related Arousal (RERA): Sequence of breaths with increasing respiratory effort leading to an arousal from sleep.

Respiratory Disturbance Index (RDI): a measurement which has at times been used synonymously with AHI, but at other times has included the total of apneas, hypopneas, and RERAs per hour of sleep.

Sleep Related Breathing Disorders (SRBDs): syndromes where the frequency of the breathing events (snoring, apneas, hypopneas, and respiratory effort related arousals (RERAs)) are pathophysiologically linked to symptoms or adverse health outcomes. These include Obstructive Sleep Apnea Syndrome (OSA), Central Sleep Apnea Syndrome (CSA), Cheyne-Stokes Respiration (CSR), and Alveolar Hypoventilation Syndrome (AHS).

Sleep specialist is defined as a physician who is Board eligible or certified by the American Board of Sleep Medicine,
a pulmonologist or neurologist whose residency/fellowship included specialized training in sleep disorders and whose practice comprises at least 25% of sleep medicine.

Unattended/Home Sleep Testing (HST) is done in the home setting and provides some of the same measurements as an in-lab sleep study (polysomnogram), such as brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation.

Codes

If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>95782</td>
<td>Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist</td>
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<tr>
<td>95783</td>
<td>Polysomnography; younger than 6 years, 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</td>
</tr>
<tr>
<td>95805</td>
<td>Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness</td>
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<tr>
<td>95808</td>
<td>Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist</td>
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<tr>
<td>95810</td>
<td>Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist</td>
</tr>
<tr>
<td>95811</td>
<td>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</td>
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Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7979 or 1-800-233-9645.


References