Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Sleep Studies		
MNG #: 008	**☒SCO ☒One Care**	**Prior Authorization Needed? ☒Yes ☐No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Medicare Benefit: ☐Yes ☒No	**Approval Date:** 1/11/2019;	**Effective Date:** 4/01/2019;
Last Revised Date: 1/25/2019, 3/26/2020;	**Next Annual Review Date:** 1/11/2020, 3/26/2021;	**Retire Date:**

OVERVIEW:

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

DEFINITIONS:

- **Home-** A member's usual place of residence.
- **In Facility**- Any location other than the member's usual place of residence.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Provider Reimbursement

The Plan reimburses diagnostic sleep studies (including polysomnography) performed in the home and outpatient settings by participating providers utilizing equipment approved by the FDA for the study setting. A member's home is the preferred testing location, provided the member meets patient selection criteria published by nationally recognized specialty organizations, such as the American Academy of Sleep Medicine. Identification of the criteria utilized to determine the appropriateness of the setting and the evaluation of the member against the criteria must be documented in the member's medical record. The documentation is subject to audit by the Plan upon request.

LIMITATIONS/EXCLUSIONS:

The Plan does not pay for:

- More than one home study per calendar year without prior authorization.
- Home studies performed using equipment not FDA approved for use in the home setting.
- In-facility studies without prior authorization.

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AUTHORIZATION:

When performed by participating providers: prior authorization is not required for the first home sleep study (one study/one night) performed in a calendar year. Prior authorization is required for all subsequent home studies performed during the same calendar year. Prior authorization is required for all in-facility studies. In-facility testing is evaluated utilizing InterQual® criteria. When performed by non-participating providers a prior authorization is required for all procedures.

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not signify whether the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the specific member's benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply. This Medical Necessity Guideline is subject to all applicable laws and regulations, Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

REGULATORY NOTES:

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Services reported on a UB-04 must be reported with an applicable revenue code and corresponding CPT/HCPCS code.

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Revenue Code	Description	
0920	Other Diagnostic Services - General	
CPT/HCPCS Code	**Description**	**Coding Instructions**
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	
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Use for an unattended sleep study done in a facility.
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Use for an unattended sleep study done in a facility.

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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 (eg, thoracoabdominal movement)	Use for an unattended sleep study done in a facility.
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	
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation	Use for a home sleep study.
G0399	Home sleep study test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	Use for a home sleep study.
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	For MH members only. Use for a home sleep study. PA is always required.

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Disclaimer:

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

RELATED REFERENCES:

N/A

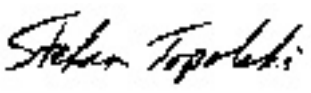
ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION

APPROVALS:

Stefan Topolski, MD	Medical Director, Medical Affairs
CCA Senior Clinical Lead [Print]	**Title [Print]**
	3/26/2020
Signature	**Date**
CCA Senior Operational Lead [Print]	**Title [Print]**

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Signature	**Date**
Lori Tishler, MD	Senior Vice President, Medical Affairs
CCA CMO or Designee [Print]	**Title [Print]**
	1/11/2019
Signature	**Date**