Clinical Policy: Sleep Apnea Diagnosis and Treatment

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Coding Implications
Revision Log

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

Description

Polysomnography (PSG) is the continuous and concurrent monitoring and recording of various physiological and pathophysiological parameters of sleep that includes physician evaluation, interpretation and dissemination. PSG is performed to diagnose various sleep disorders and evaluate the response to treatments such as continuous positive airway pressure (CPAP).[6] This policy establishes the medical necessity requirements for facility-based PSG, split-night studies, and bi-level and continuous positive airway pressure (CPAP/BiPAP) titration for suspected obstructive sleep apnea (OSA).

The policy criteria are derived from a combination of the American Academy of Sleep Medicine (AASM) guidelines[15,24], CMS local coverage determinations[6], and systematic reviews [4,5,7,10,11,20,23,26,27,28,29,30,31,32,33] which state that while PSG is currently considered the gold standard diagnostic test for OSA, home sleep apnea testing (HSAT) is an alternative method used and may be less costly and more efficient in some adult populations.[24] Indications not sourced from one of the reference types above are offered as supplemental options for meeting criteria in addition to those noted by AASM guidelines, local coverage determinations and systematic reviews.

Many HSAT devices have been validated against standard PSG, typically by testing the same patient with both modalities in the sleep laboratory. The sensitivity and specificity appear to be high in populations considered by sleep specialists to be at high risk of uncomplicated, moderate to severe OSA on the basis of clinical symptoms, assuming there are no comorbid medical disorders or other suspected sleep disorders.[11]

In addition to increased member/enrollee convenience, the main clinical advantage for HSAT is that sleep data can be obtained over several nights of sleep in the comfort of the member/enrollee's home rather than one night in a laboratory setting where the member/enrollee may not sleep for prolonged periods.

Given the performance of home sleep testing versus facility-based testing and the potential for medically appropriate members/enrollees to more closely replicate a typical night of sleep during home testing, as well as the criteria's consistency with AASM guidelines, this policy represents a favorable balance of benefits versus risks.

Note: For suspected central sleep apnea, please refer to nationally recognized clinical decision support tools.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority Billing Guidelines and Washington Administrative Code, that sleep study testing in members/enrollees **≥ 18 years of age** is **medically necessary** when meeting the following criteria:

A. Services are performed by an HCA-designated center of excellence (COE) that is an independent diagnostic testing facility, sleep laboratory, or outpatient hospital.

B. Results are used to:
   1. Establish a diagnosis of narcolepsy or sleep apnea, or
   2. Evaluate a member/enrollee's response to therapy, such as CPAP.

C. For *unattended home sleep apnea testing* (HSAT):
   1. Services are performed using one of the following HSAT devices:
      a. Type II home sleep monitoring device
      b. Type III home sleep monitoring device
      c. Type IV home sleep monitoring device that measures at least three channels
   2. Services are performed to confirm obstructive sleep apnea (OSA) in a member/enrollee with signs or symptoms consistent with OSA (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.).

D. For *full-night, in-laboratory polysomnography (PSG)*:
   1. Services are performed for either:
      a. Titration of positive airway pressure therapy when initial PSG confirms the diagnosis of OSA and positive airway pressure is ordered Type III home sleep monitoring device, or
      b. To confirm obstructive sleep apnea (OSA) in a member/enrollee with signs or symptoms consistent with OSA (e.g., loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.).

E. For *split-night, in-laboratory polysomnography (PSG)*:
   1. Services are performed for either:
      a. The apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to fifteen events per hour.
      b. The AHI or RDI is greater than or equal to five and less than or equal to fourteen events per hour with documentation of either of the following:
         i. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, or
         ii. Hypertension, ischemic heart disease or history of stroke.

II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority Billing Guidelines and Washington Administrative Code, that full-night or split-night in laboratory PSG testing in members/enrollees **age 17 or younger** is **medically necessary** when meeting the following criteria:

A. Services are performed by an HCA-designated center of excellence (COE) that is an independent diagnostic testing facility, sleep laboratory, or outpatient hospital.

B. Results are used to:
   1. Establish a diagnosis of narcolepsy or sleep apnea, or

2. Evaluate a member/enrollee's response to therapy, such as CPAP.

C. Member/enrollee meets one of the following:
   1. OSA suspected based on clinical assessment
   2. Obesity, Trisomy 21, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidosis (MPS), prior to adenotonsillectomy
   3. Residual symptoms of OSA following mild preoperative OSA
   4. Residual symptoms of OSA in a child with preoperative evidence of moderate to severe OSA, obesity, craniofacial anomalies that obstruct the upper airway, or neurologic disorder following adenotonsillectomy
   5. Titration of positive airway pressure I a child with OSA
   6. Suspected congenital central alveolar hypoventilation syndrome or sleep-related hypoventilation due to neuromuscular disorder or chest wall deformities
   7. Primary apnea of infancy
   8. Evidence of a sleep-related breathing disorder in an infant who has experienced an apparent life-threatening event
   9. Child being considered for adenotonsillectomy to treat OSA
   10. Clinical suspicion of an accompanying sleep-related breathing disorder in a child with chronic asthma, cystic fibrosis, pulmonary hypertension, bronchopulmonary dysplasia, or chest wall abnormality.

Note: chronic insomnia and snoring do not establish medical necessity unless an underlying physiology exists such as loud snoring, awakening with gasping or choking, excessive daytime sleepiness, observed cessation of breathing during sleep, etc.

III. It is the policy of Coordinated Care of Washington, Inc., that there is insufficient evidence to support the use of actigraphy testing alone for diagnosis of obstructive sleep apnea as its effectiveness has not been established.[6]

IV. It is the policy of Coordinated Care of Washington, Inc., in accordance with the HCA's Health Technology Assessment, that initial CPAP therapy is considered medically necessary when all the following CMS' NCD 240.4 criteria are met:

A. 18 years of age or older.
B. Diagnosis of OSA via a clinical evaluation and a positive sleep study which documents one of the following:
   1. AHI or RDI greater than or equal to 15 events per hour, or
   2. AHI or RDI greater than or equal to 5 events and less than or equal to 14 events per hour with documented symptoms of one of the following
      a. Excessive daytime sleepiness,
      b. Impaired cognition,
      c. Mood disorders,
      d. Insomnia, or
      e. Documented hypertension, ischemic heart disease or history of stroke.
C. For purchase of CPAP following rental period, Coordinated Care of Washington, Inc., utilizes McKessson InterQual criteria to determine medical necessity.

V. It is the policy Coordinated Care of Washington, Inc., in accordance with the HCA's Health Technology Assessment, that custom-made mandibular advancement device (MAD) is considered medically necessary as defined in Clinical Policy WA.CP.MP.500 – Mandibular Advancement Devices.

VI. It is the policy of Coordinated Care of Washington, Inc., in accordance with CMS' Local Coverage Determination (LCD) L34526 as recommended by the HCA's Health Technology Assessment, that *surgical treatment* of OSA is considered **medically necessary** when the following criteria have all been met. Note: See also CP.MP.202 – Orthognathic Surgery.

A. OSA diagnosed in a certified sleep disorders laboratory,
B. An RDI of 15 or higher
C. Failure to respond to CPAP or cannot tolerate CPAP or other appropriate non-invasive treatment such as MAD.
D. Documented counseling by a physician with recognized training in sleep disorders, about the potential benefits and risks of the surgery,
E. Additional procedure-specific criteria must be met:
    1. Uvulopalatopharynogplasty (UPPP) – evidence of retropalatal or combination retropalatal/retrolingual obstruction as the cause of the obstructive sleep apnea.
    2. Mandibular maxillary osteotomy and advancement and/or genioglossus advancement with or without hyoid suspension – evidence of retrolingual obstruction as the cause of the OSA or previous failure of UPPP to correct the OSA.
    3. Tracheostomy – when in the judgment of the attending physician OSA is unresponsive to other means of treatments or other means of treatment would be ineffective or not indicated.
    4. Surgery to correct discrete anatomic abnormalities of the upper airway (such as enlarged tonsils or an enlarged tongue) – adequate documentation in the medical records supporting significant contribution of these abnormalities to OSA.
    5. Submucous radiofrequency reduction of hypertrophied turbinates – evidence that obstruction due to turbinate hypertrophy significantly contributes to OSA or significantly compromises CPAP therapy.

Background

Sleep-disordered breathing consists of several distinct disorders including obstructive sleep apnea (OSA), central sleep apnea (CSA), both with and without Cheyne-Stokes respiration, and sleep-related hypoventilation and hypoxemia.[2,3] Sleep apnea, a serious and potentially dangerous sleep disorder in which breathing repeatedly stops and starts, is divided into two main types, OSA and CSA. [4,5,6 7] The most common form of sleep apnea, OSA, is characterized by the partial or complete collapse of the upper airway during sleep, which causes symptoms such as excessive daytime sleepiness, gasping, snorting, loud snoring, and interrupted breathing.[4,5]

The International Classification of Sleep Disorders defines OSA as five or more predominantly obstructive respiratory events per hour in the presence of symptoms or certain comorbidities; or by 15 or more predominantly obstructive respiratory events per hour in asymptomatic patients.[4] Global estimates suggest that 936 million people between the ages of 30 and 69 years old have been diagnosed with mild to severe OSA and 425 million people with moderate to severe OSA.[4]

A detailed sleep history and examination accompanied by validated screening tools such as the Epworth Sleepiness Scale or STOP-Bang questionnaire, assist with the identification of patients with sleep-disordered breathing.[8] However, sleep testing is necessary for diagnostic confirmation.[8]

OSA should be suspected when a patient presents with excessive daytime sleepiness, snoring and choking, or gasping during sleep, especially in the presence of high-risk factors like advanced age and obesity, and in those with a male reproductive system. Additional complications related to OSA include refractory hypertension, atrial fibrillation, nocturnal angina, dysrhythmias, congestive heart failure, stroke, and transient ischemic attacks.[4, 9,10]

Polysomnography (PSG) is a comprehensive sleep study that monitors several physiologic components relevant to the assessment of sleep-disordered breathing such as sleep stage, respiratory flow, respiratory effort, pulse oximetry and ventilation.[2,12] PSG results are interpreted by the reviewing clinician and treatment recommendations are made based on the recorded signals, results of scoring, and clinical history.[13] PSG tests can be used as a part of the diagnosis of a variety of additional sleep disorders including sleep-related movement disorders, narcolepsy, and certain parasomnias.[13] They are also used for titration of positive airway pressure and to assess the adequacy of ongoing therapy.[12,14]

PSG is conducted as a full-night study or split night study. A full night study involves monitoring the patient overnight, and if OSA is diagnosed, a return to the facility for PAP titration is sometimes necessary. A split-study involves monitoring of the patient's sleep pattern for the first part of the night, and if OSA is diagnosed, PAP titration is initiated the second part of the night.[4]

Home sleep apnea testing (HSAT) may be an appropriate, less stressful option for select patients with a high pretest probability of moderate to severe uncomplicated OSA, provided there is no suspicion of non-respiratory sleep disorders (e.g., narcolepsy, severe insomnia, parasomnias, movement disorders); no significant cardiorespiratory disease (e.g., COPD, asthma, CHF); they are not a mission-critical worker (e.g., airline pilot, bus driver, truck driver, astronaut); and a sleep expert is available to interpret the results.[4,5,12,15,16]

The most common HSAT devices currently used are classified as sleep monitoring devices of type 3 and type 4. Type 3 is preferred to type 4 because of the additional number of variables measured- four to seven versus one to three variables. The AASM considers home monitoring devices adequate when a minimum of the following sensors are included: nasal pressure, chest and abdominal respiratory inductance plethysmography, oximetry, or peripheral artery tone (PAT), actigraphy, oximetry.[4,11,17]

Studies have demonstrated the validity of HSAT results when compared to facility-based PSG. They note high sensitivity and specificity in populations at high risk of moderate to severe OSA based on clinical symptoms and in the absence of significant comorbidities that affect sleep or non respiratory sleep disorders.[4,11,17]

Advantages of HSAT include the convenience of testing at home and cost effectiveness.[11] The primary disadvantage of HSAT is that fewer physiologic variables are measured when compared with facility-based PSG, which can increase the likelihood for false-negative results. For most patients with suspected mild OSA, facility-based PSG in a is preferred since HSAT may lead to the under detection of sleep-related events in this population.[4,11]

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 2023, 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 that support coverage

CPT® Codes	Description
21193	Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy, without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C or L osteotomy, with bone graft
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental
21685	Hyoid myotomy and suspension
42145	Palatopharnyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty)
95806	Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort
95800	Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory analysis and sleep time
95801	Sleep study, unattended, simultaneous recording of minimum of heart rate, oxygen saturation, respiratory analysis.
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 CPAP or BiPAP, 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 CPAP or BiPAP, attended by a technologist

HCPCS Codes	Description
A7027	Combination oral/nasal mask used with positive airway pressure device
A7030	Full face mask used with positive airway pressure device
A7031	Face mask interface, replacement for full face mask
A7033	Nasal pillow, replacement
A7034	Nasal mask used with positive airway pressure device
A7035	Headgear used with positive airway pressure device
A7036	Chin strap used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Disposable filter used with positive airway pressure device
A7039	Non-disposable filter used with positive airway pressure device
A7044	Oral interface used with positive airway pressure device
E0601	CPAP Device
E0470	BiPAP without back-up rate feature
E0471	BiPAP with back-up rate feature, used with noninvasive interface
E0472	BiPAP with back-up rate feature, used with invasive interface (tracheostomy)
E0561	Humidifier, nonheated, used with positive airway pressure device
E0562	Humidifier, heated, used with positive airway pressure device

CPT codes that do not support coverage

CPT®* Codes	Description
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	10/19	11/19
Attended sleep study criteria added. References reviewed and updated.	07/20	08/20
Clarified Attended Sleep Study criteria. Updated references.	08/20	09/20
Highlighted definitions of hypopnea and apnea. Added comments and criteria on CPAP titration. Clarified guidelines when home study fails.	10/20	11/20
Added III. D. indicating titration can be requested after initial authorization	02/21	03/21
Moved section III on CPAP titration to be section II and expanded this section. Added qualifying statements to I.A., I.H. and I.I. Added language for sleep-related hypoventilation. Made minor changes to	10/21	11/21

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Description. Changed logo and company description as policy was adopted for Ambetter. Updated Background and References. Replaced "members" with "members/enrollees".		
Added reference to new policy CP.MP.202 – Orthognathic Surgery	11/21	12/21
Corrected I.B. to indicate "HFrEF of 40% or **less**"	03/22	03/22
Updated policy to reflect new Centene policy: significant changes to section I.B. and change in policy numbering from WA.CP.MP.523 to WA.CP.MP.248. Updated section II.A. to reflect consideration of titration studies. Minor changes to company name. Updated references.	02/23	02/23
Policy archived	06/23	06/23
Re-established policy. Revised Sections I and II extensively to mirror HCA Billing Guideline.	08/25	09/25

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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.

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Note: For Medicaid members/enrollees, 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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.