

functioning of a malformed body member.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim which lacks the necessary documentation to process the claim.

42 CFR §410.32 indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements).

CMS Manual System, Pub 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1, §30.4 Electrosleep Therapy and Part 4, &240.4, Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA) (Effective April 4, 2005)(Effective March 13, 2008); §240.4.1 Sleep Testing for Obstructive Sleep Apnea (OSA)(Effective 03/03/2009).

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §70, Sleep Disorder Clinics

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 6, §50, Sleep Disorder Clinics

Indications and Limitations of Coverage and/or Medical Necessity

Polysomnography is the continuous measurement and recording of physiological activities during sleep. During polysomnography, several parameters are recorded to establish a diagnosis or rule out sleep apnea, narcolepsy and other sleep disorders. The studies are also performed to evaluate a patient's response to therapy, such as CPAP (continuous positive airway pressure).

The coverage of impotence, which may involve sleep testing, is not addressed in this LCD.

Polysomnography is the continuous, simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 6 hours or more, and includes a physician review, interpretation and report. Testing is covered when performed by an Independent Diagnostic Testing Facility for Sleep Disorders, a sleep laboratory or hospital. These are facilities in which certain conditions are diagnosed through the study of sleep and must be under the supervision of a physician. These entities are for diagnosis, therapy, and research and may be affiliated with a hospital or be a freestanding facility. Some diagnostic or therapeutic services that are provided by these facilities may be covered under Medicare. Whether the facility is affiliated with a hospital or is freestanding and under the direction and control of physicians, coverage for diagnostic services under some circumstances is allowed under provisions of the law that are different from those for coverage of therapeutic services.

Diagnostic testing that is routinely performed by Independent Diagnostic Testing Facilities for Sleep Disorders may be covered even in the absence of **direct** supervision by a physician, however, a trained, qualified attendant must be present to assess and monitor the patient. Patients are referred to the Independent Diagnostic Testing Facilities for Sleep Disorders by their attending physician. These testing facilities are expected to maintain a record of the attending physician's orders. The need for diagnostic testing is confirmed by medical evidence, for example, physician examinations and laboratory tests. Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered because it is not reasonable and necessary.

Continuous Positive Airway Pressure (CPAP) Device

Durable Medical Equipment

A. General

Continuous positive airway pressure (CPAP) is a non-invasive technique for providing single levels of air pressure from a flow generator, via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP. The use of CPAP devices must be ordered and prescribed by the licensed treating physician to be used in adult patients with moderate to severe OSA if either of the following criterion using the Apnea-Hypopnea Index (AHI) or Respiratory Distress Index(RDI) are met:

? AHI or RDI greater than or equal to 15 events per hour, or

? AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The Respiratory Disturbance Index (RDI) is equal to the average respiratory disturbances per hour. Both should be based on a minimum of 2 hours of sleep recorded, if the AHI or RDI is calculated on less than two hours of continuously recorded sleep, the total number of recorded events to calculate the AHI or RDA during sleep testing must be at a minimum the number of events that would have been required in a two hour period.

These tests are recorded by polysomnography or by sleep testing devices that are unattended in or out of a sleep lab facility or attended in a sleep lab facility using a FDA approved Type II, III, or IV portable device recording at least 3 channels using actual recorded hours of sleep.

Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.

The polysomnography must be performed in a facility-based sleep study laboratory, and not in the home or in a mobile facility.

Performance of home sleep testing is limited to FDA cleared devices furnished with adequate patient instruction and support to assure successful completion of the studies. Provision of the device, patient instruction and support can be provided by accredited sleep centers as well as Independent Diagnostic Testing Facilities and other entities that can demonstrate use of FDA approved devices, inspection of the devices, and the patient support activities required. The provider may be subject to post payment audit to document these activities.

Physician services related to home sleep testing are covered for the purpose of determining a diagnosis of OSA if:

- It is reasonable and necessary for the diagnosis of the patient's condition
- It is performed for patients with a high pretest probability of moderate to severe OSA
- It is performed in conjunction with a comprehensive sleep evaluation
- It meets all other Medicare requirements

The DMAC (Durable Medical Equipment Administrative Contractors) are responsible for providing CPAP devices. They have published a policy that requires the following standards of credentialing for individuals who interpret sleep testing results that are required for Medicare coverage of CPAP.

"Home sleep testing must be interpreted by a physician who holds either:

- a) Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or
- b) Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or
- c) Completed residency or fellowship training by a program approved 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
- d) Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission.

Note: Physicians interpreting polysomnograms will be required to meet this requirement for coverage of PAP devices provided after January 1, 2010."

The claim must also certify that the documentation supporting a diagnosis of OSA (described above) is available.

Nationally Non-covered Indications

"Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which is defined to include a 1-4 lead electroencephalogram (EEG), an electrooculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include:

1. ECG (electrocardiogram)
2. airflow
3. ventilation and respiratory effort
4. gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis
5. extremity muscle activity, motor activity-movement
6. extended EEG monitoring
7. penile tumescence
8. gastroesophageal reflux
9. continuous blood pressure monitoring
10. snoring
11. body positions, etc.

For a study to be reported as a polysomnogram, sleep must be recorded and staged." (CPT 2005)

The Multiple Sleep Latency Test (MSLT) is a standardized and well-validated measure of physiologic sleepiness. The same parameters as for basic Polysomnography (PSG) are monitored, (usually two eye movements and two EEG [central and occipital] channels, in addition to EKG, airflow, and submental EMG). The MSLT consists of 4-5 twenty-minute nap opportunities offered at two-hour intervals. The MSLT is designed to quantitate sleepiness to determine the need for treatment, and to determine the premature occurrence of REM (rapid eye movement) sleep. Studies in normals have demonstrated that the latency to sleep onset during these naps is correlated with the duration of sleep on one or several nights preceding the study, maturation, age, continuity of sleep, time of day, and ingestion of drugs. Pathologic ranges of sleep latency have been carefully defined. To insure validity, proper interpretation of the MSLT can only be made following a PSG that was performed on the preceding night. For each nap, the latency between "lights out" and sleep onset is determined. A mean latency of 5 minutes or less indicates severe excessive sleepiness. The number of naps during which REM sleep appears is also noted. Repeat MSLT testing is necessary only when 1) the initial test is believed to be an invalid representation of the patient's status; 2) the initial test is inconclusive; 3) the response to treatment needs to be ascertained; or 4) more than one sleep disorder is suspected.

Polysomnography and/or Multiple Sleep Latency studies are done and covered only if the patient has symptoms or complaints suggesting a diagnosis of one of the following conditions:

A. Narcolepsy

This term refers to a syndrome that is characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep. Related diagnostic testing is covered if the patient has inappropriate sleep episodes or attacks, for example, while driving, in the middle of a meal, or in the middle of a conversation. Other examples include amnesiac episodes or continuous disabling drowsiness. Ordinarily, for a diagnosis of narcolepsy to be made, at least three naps are required. The diagnosis can be confirmed by polysomnography or Multiple Sleep Latency Testing. If more than three naps are claimed, there must be persuasive medical evidence to justify the necessity for additional test(s).

B. Sleep Apnea

This is a potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described (central, obstructive and mixed). The nature of the apnea episodes can be documented by appropriate diagnostic testing. Sleep apnea can be diagnosed by a single polysomnogram, including EEG leads, for a minimum of 6 hours. CPT 2005 describes sleep testing as follows: "Sleep studies and polysomnography refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 6 or more hours with physician review, interpretation and report. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as,

nasal continuous positive airway pressure (NCPAP).”

C. Impotence

Polysomnography and Sleep Studies for impotence are not addressed in this policy.

D. Parasomnia

Parasomnias are a group of conditions that represent undesirable or unpleasant occurrences during sleep. Behavior during these times can often lead to damage to the surroundings and injury to the patient or to others. Parasomnia may include conditions such as sleepwalking, night terrors, and rapid eye movement (REM) sleep behavior disorders. In many of these cases, the nature of these conditions may be established by careful clinical evaluation. Suspected seizure disorders as the possible cause of parasomnia are appropriately evaluated by standard or prolonged sleep EEG (electroencephalogram) studies. In cases where seizure disorders have been ruled out and in cases that present a history of repeated violent or injurious episodes during sleep, polysomnography may be useful in providing a diagnostic classification or prognosis.

E. Polysomnography for Chronic Insomnia is not covered.

Evidence at the present time is not convincing that polysomnography in a sleep disorder clinic for chronic insomnia provides definitive diagnostic data; or that such information is useful in patient treatment; or is associated with improved clinical outcome. The use of polysomnography for the diagnosis of patients with chronic insomnia is not covered under Medicare because it is not reasonable and necessary.

F. Coverage of Therapeutic Services:

Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Therapeutic services may be covered in a hospital outpatient setting or in a freestanding facility provided that they meet the pertinent requirements for the particular type of services, are reasonable and necessary for the patient, and are performed under the direct supervision of a physician.

Most of the patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over. The overnight stay is considered an integral part of these tests.

Polysomnography includes sleep staging which is defined to include a 12-4 lead electroencephalogram (EEG), electrooculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep include electrocardiogram (ECG); airflow; ventilation and respiratory effort; gas exchange by oximetry, transcutaneous monitoring or end tidal gas analysis; extremity muscle activity and/or motor activity; extended EEG monitoring; continuous blood pressure monitoring; snoring; and body positions, etc. For a study to be reported as a polysomnogram, sleep must be recorded and staged. The study should be performed in a hospital, an independent diagnostic testing facility or a sleep laboratory, be attended by a trained technologist and must be an observed study.

Polysomnography may be indicated for snoring when an overnight oximetry indicates desaturation to below 90% greater than 5% of the time. A combined diagnostic/therapeutic (CPAP) study may be indicated.

Snoring and nasal obstructive signs and symptoms are not, in and of themselves, indications for polysomnography, however, they may be indications of sleep apnea when other findings are also present. Other causes of sleepiness should be ruled out via a sleepiness scale before performing a sleep study.

Indications and Limitations:

Polysomnography is performed to diagnose a variety of sleep disorders which include, but are not limited to daytime somnolence, reports of sleeping/napping during the day, falling asleep at work or when driving and witnessed apneic episodes.

Sleep studies may also be indicated to evaluate a patient’s response to certain therapy, for example, CPAP, for snoring when an overnight oximetry indicates desaturation below 90% greater than 5% of the time.

For a study to be reported as a polysomnogram, sleep must be recorded and staged and must be **attended**.

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— Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

999x	Not Applicable
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Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999	Not Applicable
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CPT/HCPCS Codes**CPT Codes**

95800	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; HEART RATE, OXYGEN SATURATION, RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE), AND SLEEP TIME
95801	SLEEP STUDY, UNATTENDED, SIMULTANEOUS RECORDING; MINIMUM OF HEART RATE, OXYGEN SATURATION, AND RESPIRATORY ANALYSIS (EG, BY AIRFLOW OR PERIPHERAL ARTERIAL TONE)
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)
95807	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, ATTENDED BY A TECHNOLOGIST
95808	POLYSOMNOGRAPHY; SLEEP STAGING WITH 1-3 ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST
95810	POLYSOMNOGRAPHY; SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST
95811	POLYSOMNOGRAPHY; 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

HCPCS Codes

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
G0399	HOME SLEEP TEST (HST) WITH TYPE III PORTABLE MONITOR, UNATTENDED; MINIMUM OF 4 CHANNELS: 2 RESPIRATORY MOVEMENT/AIRFLOW, 1 ECG/HEART RATE AND 1 OXYGEN SATURATION
G0400	HOME SLEEP TEST (HST) WITH TYPE IV PORTABLE MONITOR, UNATTENDED; MINIMUM OF 3 CHANNELS

ICD-9 Codes that Support Medical Necessity

These are the **only** covered ICD-9-CM codes that support medical necessity for CPT codes 95800, 95801, 95805, 95807, 95808, 95810 G0398 G0399, and G0400:

278.01	MORBID OBESITY
278.03	OBESITY HYPOVENTILATION SYNDROME
307.46	SLEEP AROUSAL DISORDER
307.47	OTHER DYSFUNCTIONS OF SLEEP STAGES OR AROUSAL FROM SLEEP
307.48	REPETITIVE INTRUSIONS OF SLEEP
327.10	ORGANIC HYPERSOMNIA, UNSPECIFIED
327.11	IDIOPATHIC HYPERSOMNIA WITH LONG SLEEP TIME
327.12	IDIOPATHIC HYPERSOMNIA WITHOUT LONG SLEEP TIME
327.20	ORGANIC SLEEP APNEA, UNSPECIFIED
327.21	PRIMARY CENTRAL SLEEP APNEA
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
327.24	IDIOPATHIC SLEEP RELATED NON OBSTRUCTIVE ALVEOLAR HYPOVENTILATION
327.25	CONGENITAL CENTRAL ALVEOLAR HYPOVENTILATION SYNDROME
327.26	SLEEP RELATED HYPOVENTILATION/HYPOXEMIA IN CONDITIONS CLASSIFIABLE ELSEWHERE
327.27	CENTRAL SLEEP APNEA IN CONDITIONS CLASSIFIED ELSEWHERE
327.29	OTHER ORGANIC SLEEP APNEA
327.40	ORGANIC PARASOMNIA, UNSPECIFIED
327.41	CONFUSIONAL AROUSALS
327.42	REM SLEEP BEHAVIOR DISORDER
327.51	PERIODIC LIMB MOVEMENT DISORDER
347.00	NARCOLEPSY, WITHOUT CATAPLEXY

347.01	NARCOLEPSY, WITH CATAPLEXY
347.10	NARCOLEPSY IN CONDITIONS CLASSIFIED ELSEWHERE, WITHOUT CATAPLEXY
347.11	NARCOLEPSY IN CONDITIONS CLASSIFIED ELSEWHERE, WITH CATAPLEXY
780.09	ALTERATION OF CONSCIOUSNESS OTHER
780.51	INSOMNIA WITH SLEEP APNEA, UNSPECIFIED
780.53	HYPERSOMNIA WITH SLEEP APNEA, UNSPECIFIED
780.54	HYPERSOMNIA, UNSPECIFIED
780.55	DISRUPTION OF 24 HOUR SLEEP WAKE CYCLE, UNSPECIFIED
780.56	DYSFUNCTIONS ASSOCIATED WITH SLEEP STAGES OR AROUSAL FROM SLEEP
780.57	UNSPECIFIED SLEEP APNEA
780.58	SLEEP RELATED MOVEMENT DISORDER, UNSPECIFIED
780.59	OTHER SLEEP DISTURBANCES
786.04	CHEYNE-STOKES RESPIRATION
799.02	HYPOXEMIA

Diagnoses that Support Medical Necessity

All ICD-9-CM codes listed in this policy under ICD-9-CM Codes That Support Medical Necessity above.

ICD-9 Codes that DO NOT Support Medical Necessity

All ICD-9-CM codes **not** listed in this policy under ICD-9-CM Codes That Support Medical Necessity above.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**Diagnoses that DO NOT Support Medical Necessity**

All ICD-9-CM codes **not** listed in this policy under ICD-9-CM Codes That Support Medical Necessity above.

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General Information

Documentations Requirements

The medical record must document signs and symptoms to support reasonable and necessary indications for performing a sleep study and must be available to Medicare upon request.

These signs or symptoms should include, but are not limited to: daytime somnolence, witnessed apneic episodes, reports of sleeping/napping during the day, falling asleep at work or when driving.

Note: For a study to be reported as polysomnography, sleep must be staged and recorded. Performance of home sleep testing is limited to FDA cleared devices furnished with adequate patient instruction and support to assure successful completion of the studies.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.

When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the appeal request.

Appendices**APPENDIX A****Narcolepsy**

Narcolepsy is a chronic ailment consisting of recurrent attacks of drowsiness and sleep during daytime. More than 125,000 people in the United States have narcolepsy. The patient is unable to control these spells of sleep but is easily awakened. These attacks may be distinguished from ordinary drowsiness following a meal by the frequency of occurrence of attacks in narcolepsy, their irresistibility, and their happening in unusual circumstances, such as while eating, standing, or conversing.

About 40% of these patients will have some form of cataplexy; sudden loss of muscle tone brought on by some strong emotion such as laughter, surprise, or anger. The knees may buckle, the head will fall forward, and the person may fall to the ground but remain conscious.

Diagnosis:

Results of the Multiple Sleep Latency Test are positive in that the patient falls asleep within less than 5 minutes if asked to try to

sleep at 2-hour intervals throughout the day. In addition, there will be abnormalities of rapid eye movement (REM) sleep during at least two of these sleep periods.

Narcolepsy occurs in families and is probably controlled by a specific gene. It is also present as a familial disorder in cats, certain breeds of dogs, ponies, quarterhorses, and Brahma bulls. Except for frequent sleep patterns, the electroencephalogram is normal.

The etiology of this disease is unknown. It is not related to epilepsy or migraine. It is characterized by excessive daytime sleepiness and irresistible sleep attacks. These episodes may last from seconds to minutes and may occur two to six times a day. In addition, the narcoleptic may have episodes of lapse of consciousness accompanied by automatic behavior, followed by amnesia. The diagnosis is confirmed by finding short-period REM sleep during the time the patient would normally be awake.

Treatment:

Symptomatic with drugs such as ephedrine or dextroamphetamine sulfate or methylphenidate hydrochloride. In addition, 15 minute naps planned to coincide with known time of occurrence of drowsiness will help.

Sleep Disorders:

Sleep disorders are any condition that interferes with sleep. This definition does not include the environmental factors that can disrupt sleep such as noise, excess heat or cold, or movement, as on a train, bus, or ship.

Cataplexy:

The brief, sudden loss of muscle control brought on by strong emotion, such as a hearty laugh, excitement, surprise, or anger. Even though this may cause collapse, the patient remains fully conscious. The episode will last from seconds to minutes. Once the condition begins, it usually continues, but may be less severe with age. Most patients with narcolepsy will also have cataplexy.

Treatment:

Imipramine hydrochloride and Tofranil is of benefit.

Nightmares:

These bad dreams occur in children and adults during REM sleep. The dream usually involves falling, death, or fear of attack. In the usual circumstance, nightmares are of no clinical importance, but they may be an indication of chronic alcohol or drug intoxication or withdrawal of drugs such as barbituates.

Night Starts:

Sudden "starts" or "jerks" that come during the transition between wakefulness and sleep. They may be intense enough to awaken the person. Even though these sudden movements may be of concern to the individual, he or she should be told that they are of no clinical importance.

Night Terrors:

Shortly after falling asleep, the person awakens in fright, crying or screaming or moaning. There is tachycardia and hyperventilation. The episode lasts for only a few minutes, and it is not usually remembered the next morning. These usually begin in childhood but do not occur in adults.

Sensory Paroxysms:

At the onset of sleep, a sensation of hearing a sudden loud sound, a flash of light, or of being lifted and hurled to earth. Except for the disruption of sleep, these events are benign.

Sleep Apnea:

The symptom of a group of disorders characterized by cessation of breathing during sleep. In order to be so classified, the apnea lasts for at least 10 seconds and occurs 30 or more times during a seven-hour period of sleep. This strict definition may not apply to older persons in whom periods of sleep apnea are increased. The disorder is classified according to the mechanism involved: 1) obstructive sleep apnea during which respiratory effort is present but is ineffective because of obstruction to the upper airway; 2) central sleep apnea which is associated with the absence of respiratory muscle activity; and 3) mixed apnea, when the apnea begins with absence of respiratory effort that is followed by upper airway obstruction.

Patients with obstructive sleep apnea are usually middle-aged, obese men with a history of excessive daytime sleepiness and sleep apnea associated with loud snoring, snoring, and gasping sounds.

The patient with central sleep apnea may present with excessive daytime sleepiness, but the snoring and gasping sounds during sleep are absent.

Treatment:

Primary therapy is to assist breathing with continuous positive airway pressure. Correct the underlying disease, weight loss, surgical correction of palatal obstruction by uvulopalatopharyngoplasty. Medroxyprogesterone (Provera) may be of benefit.

Sleep Paralysis:

Condition of being unable to speak or move even though fully aware of external events. Most commonly occurs upon falling asleep. The attack usually is of short duration, but to the patient, the elapsed time may seem like hours. The exact cause or explanation of this condition is unknown.

Sleep Walking:

This condition occurs mostly in children, and each episode usually lasts for less than 10 minutes. The patient appears to awaken, sits on the edge of the bed, and may walk. The eyes are open and the facial expression is blank. Even though their movements are clumsy, patients avoid obstructing objects. Night terrors may accompany sleepwalking. There is little memory of the event.

Treatment:

The principal concern is to prevent injury by removing objects that could be dangerous and locking doors and windows, and to prevent from falling down stairs. Children usually outgrow this benign condition.

Utilization Guidelines

Sources of Information and Basis for Decision

American Academy of Sleep Medicine. Accreditation Information. Available at: <http://www.aasmnet.org/> Accessed on 3/03/2011.

Facts about Sleep Apnea, Narcolepsy, Insomnia and Other Sleepiness Problems. National Heart Lung and Blood Institute (NHLBI). Available at: <http://www.nhlbi.nih.gov/health/prof/sleep/index.htm#pub> Accessed 03/03/2011.

Hoffstein V. Blood Pressure, Snoring, Obesity, and Nocturnal Hypoxemia. *Lancet*. Sep 1994;344(8923):643-5.

Polysomnography and Sleep Disorder Centers. Technology Assessment report abstract. Agency for Health Care Policy and Research, Rockville, MD. Available at: <http://www.ahrq.gov/clinic/sleep2.htm>. Accessed 03/03/2011.

Crisp AH, Matthews BM, Oakey M, Crutchfield M. Sleepwalking, Night Terrors, and Consciousness. *BMJ* Feb 1990;10:300 (6721):360-2.

Wiegand L, Zwillich CW. Obstructive Sleep Apnea. *Dis Mon* Apr 1994; 40(4):197-252.

Assessment: Techniques Associated with The Diagnosis and Management of Sleep Disorders. *American Academy of Neurology* 1992;42:269-75.

Specialty Consultants

Carrier Medical Directors

UPDATED SOURCES

Sleep Disorders. National Institutes of Health (NIH). Available at: <http://www.nlm.nih.gov/> Accessed 03/03/11.

Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which include representatives from the affected provider community.

Contractor Advisory Committee meeting dates:

California - 11/19/2008

Hawaii - 10/31/2008

Nevada - 11/06/2009

Start Date of Comment Period

10/30/2008

End Date of Comment Period

12/31/2008

Start Date of Notice Period

01/23/2009

Revision History Number

Revision #10

Revision History Explanation

Revision #10 effective for dates of service on or after 03/10/2011.

Revision made: The revision of this LCD was done for clarification purposes that the coverage of impotence is not addressed in the Polysomnography and Sleep Studies for Testing Sleep and Respiratory Disorders LCD. Under Indications and Limitations of Coverage and/or Medical Necessity a second paragraph was added to clarify that the coverage of impotence, which may involve sleep testing, is not addressed in this LCD. The introductory paragraph describing the conditions for which polysomnography and/or multiple sleep latency studies are done the words "excluding impotence" was removed. Under subheading C. Impotence, the sentence was restructured to read "Polysomnography and Sleep Studies for impotence are not addressed in this policy." Under Sources of Information and Basis for Decision updated web site address for articles titled Facts about Sleep Apnea, Narcolepsy, Insomnia and other Sleepiness Problems as it had changed since January 2011 when last accessed.

Revision #9 effective for dates of service on or after 01/13/2011.

Revisions made: Under Sources of Information and Basis for Decision updated name and web site for the "American Sleep Disorders Association, Accreditation Information" as the American Academy of Sleep Medicine (AASM), formerly the American Sleep Disorders Association has changed its name and web site address. Removed citation titled American Sleep Disorders Association, Medicine, Research, Education and website, as this is a defunct organization. Medical, Research, and Education are available at the American Academy of Sleep Medicine (AASM) corrected the web site address. Updated web address for National Heart Lung and Blood Institute, the reference to National Institutes of Health will be added as another resource which was added as an updated source. Removed the citation "The American Board of Sleep Medicine, Board Certification in Sleep," as the organization has suspended its administration of sleep medicine examinations. The American Board of Medical Specialties (American Board of Internal Medicine, American Board of Psychiatry & Neurology, American Board of Pediatrics, etc.) are administering an examination in sleep medicine. The AMSM continues to maintain and verify the records of the diplomats of the ABSM for dates prior to January 1, 2007. Removed web site address for article titled "Blood Pressure, Snoring, Obesity, and Nocturnal Hypoxemia" as the web

address is no longer a valid address. Corrected web site address for article titled, Polysomnography and Sleep Disorder Centers. Removed citation titled "Obstructive Sleep Apnea Widely Undiagnosed" unable to locate article. Removed web site address for article titled "Sleepwalking, Night Terrors, and Consciousness as web site not available. Removed web site address for article titled "Obstructive Sleep Apnea" as web site not available. Removed citation titled "Current Pharmacologic Management of Narcolepsy" as the Journal listed did not have the article listed and the website is no longer available and MDX Health Digest database has been discontinued since Dec. 2004. Corrected citation publication information for article titled "Assessment: Techniques Associated with the Diagnosis and Management of Sleep Disorders. Added citation "Sleep Disorders" National Institutes of Health (NIH) and added web site address.

Revision #8 effective for dates of service on or after 01/01/2011.

Revision made: Under "CPT/HCPCS Codes" added CPT codes 95800 and 95801. CPT codes 95807, 95808 and 95810 had short description changes. This revision was due to the 2011 CPT/HCPCS Annual Update.

Revision #7 effective for dates of service on or after 10/01/2010

Revisions made: Under "Indications and Limitations of Coverage and/or Medical Necessity" removed the statement, "Initial claims must be supported by documentation (separate documentation where electronic billing is used), such as a prescription written by a patient's attending physician that specifies: a diagnosis of moderate or severe obstructive sleep apnea and surgery is a likely alternative. This was removed as this is a requirement for the DMAC for a CPAP or Bi-PAP device. Under "ICD-9 Codes that Support Medical Necessity," ICD-9 code 278.03 was added per the Annual Update of International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM) per CR 7006, Transmittal 2017, and dated August 4, 2010. ICD-9 code 786.04 was placed in the LCD to be consolidated with J1 Part A Polysomnography and Sleep Studies, the is code is effective for dates of service on or after 03/09/2009.

Revision #6 effective for dates of service on or after 9/24/2009

Revision made: Under CMS National Coverage Policy" added CMS Manual System, Pub 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §30.4 Electrosleep Therapy and Part 4, &240.4, Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA) (Effective April 4, 2005) (Effective March 13, 2008); and §240.4.1 Sleep Testing for Obstructive Sleep Apnea (OSA)(Effective 03/03/2009) was manualized.

Revision #5 effective for dates of service on or after 08/10/2009.

Revisions made: Under section titled "CMS National Coverage Policy", Pub. 100-03, Chapter 1 Part 4, §240.4 the section was changed to 240.4.1. Under Indications and Limitations of Coverage and/or Medical Necessity, subtitle Continuous Positive Airway Pressure (CPAP) Device the paragraph referring sleep testing devices Type II, III or IV now states that these tests are covered if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

Revision #4 03/09/2009

This LCD is being revised to implement the streamlining of the Part B LCDs per the published article "Palmetto Team to Streamline Part B LCDs in Jurisdiction 1 (J1)." This article can be viewed at www.PalmettoGBA.com by searching for the above article name. This revision will become effective on 03/09/2009.

Revision #3 effective on or after 03/09/2009

Revisions made: Under "CMS National Coverage Policy" deleted the reference to the Medicare National Coverage Determination/Decision Memo CAG-00093R2 as this has been manualized. The current effective date was added to the following citation: CMS Manual System, Pub 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, §240.4 Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (Effective April 4, 2005) (Effective March 13, 2008). Added references 42 CFR §410.32 and Medicare Benefit Policy Manual Chapter 6, §50. "Indications and Limitations of Coverage and/or Medical Necessity" section added credentialing requirement for an individuals who interpret sleep testing results that are required for coverage of the CPAP device as cited from the DMAC LCD and clarified the NCD for Continuous Positive Airway Pressure (CPAP) for Obstructive Sleep Apnea (OSA) were added. Added information regarding the home sleep testing devices and requirements that must be met when furnishing a patient with the device. "HCPCS/CPT Code" the following codes were added: 95806, G0398, G0399 and G0400. "ICD-9 Codes that Support Medical Necessity" the following ICD-9 codes were added: 307.46, 307.47, 307.48, 327.10, 327.11, 327.12, 327.20, 327.21, 327.24, 327.25, 327.26, 327.27, 327.29, 327.40, 327.41, 327.42 and 327.51. ICD-9 codes 278.8, 345.80, 345.81 were deleted. Under "Documentation Requirements" removed duplicate citation referenced in the "CMS National Coverage Policy." Added the statement, "home sleep testing is limited to FDA cleared devices furnished with adequate patient instruction and support to assure successful completion of the studies." "Documentation Requirements" under "Note" added verbiage regarding home sleep testing devices must be FDA cleared and adequate instruction and support must be provided to the patient. Under Advisory Committee Meetings Notes added the dates for the specific Contractor Advisory Committee Meetings. This notice period becomes effective 01/23/2009. This revision becomes effective 03/09/2009.

Revision #2, 09/02/2008

This revision addresses the full implementation of NCD Decision Memo CAG-00093R2.

Revision #1, 09/02/2008

This LCD is being revised to add Bill Type 999X because the automated system transcription process was incomplete.

11/15/2009 - The description for CPT/HCPCS code 95806 was changed in group 1

11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:

95807 descriptor was changed in Group 1

95808 descriptor was changed in Group 1

95810 descriptor was changed in Group 1

Reason for Change

Last Reviewed On Date

03/03/2011

Related Documents

Article(s)

A48408 - Response to Comments for Polysomnography and Sleep Studies for Testing Sleep and Respiratory Disorders Local Coverage Determination (LCD) J1B-08-0064-L opens in new window

LCD Attachments

There are no attachments for this LCD.

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