DRAFT

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
1A-27: Electrodiagnostic Studies

1.0 Description of the Procedure, Product, or Service

Polysomnography (PSG), ~~also called known as a sleep study, is a test~~ and sleep studies are used to diagnose sleep disorders and record nighttime sleep patterns. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging. Polysomnography records brain waves, the oxygen level in blood, heart rate, breathing, eye and leg movements during the study.

Polysomnography is usually done at a sleep disorders unit within a hospital or at a sleep center. Polysomnography is occasionally done during the day to accommodate shift workers who habitually sleep during the day.

In addition to helping diagnose sleep disorders, polysomnography may be used ~~to help adjust treatment plans, if a diagnosis of a sleep disorder has been made.~~ to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP).

1.1 Definitions

1.1.1 Chronic Insomnia

Chronic insomnia, or long-term insomnia, is defined as a person having difficulty sleeping at least three nights a week for one month or longer. At least ONE of the following conditions must be met:

a. Diagnosis is uncertain;
b. Sleep related breathing disorder or periodic limb movement disorder is suspected;
c. A beneficiary is refractory to treatment;
d. Violent behaviors are comorbid; or
e. Circadian dysrhythmias complicate the clinical picture.

1.1.2 Home Sleep Test (HST) or Unattended Sleep Study

Sleep testing is performed using unattended portable monitors for the diagnosis of obstructive sleep apnea. Home sleep testing is also called an Unattended Sleep Study, as a technologist is not present.

1.1.3 Hypoventilation

Hypoventilation is defined as a potentially lethal condition involving decreased ventilation associated with an increase in CO2 levels and possibly hypoxemia.

1.1.4 Maintenance of Wakefulness Test

The Maintenance of Wakefulness Test (MWT) means a test used to measure alertness during the day. It shows whether or not someone is able to stay awake

for a defined period of time. This is an indicator of their ability to function and remain alert in quiet times of inactivity. It involves multiple trials throughout a day of low-demand activity when the instructions are to resist sleep.

1.1.5 Multiple Sleep Latency Test

The Multiple Sleep Latency Test (MSLT) means a test that measures excessive daytime sleepiness by determining how quickly someone can fall asleep in a quiet environment during the day. Also known as a daytime nap study, the MSLT is the standard tool used to diagnose narcolepsy and idiopathic hypersomnia.

1.1.6 Narcolepsy and Idiopathic Hypersomnolence

Narcolepsy and idiopathic hypersomnolence are defined as syndromes characterized by abnormal sleep tendencies. Symptoms ~~include~~ are:

a. inappropriate sleep episodes or attacks (while driving, in the middle of a meal, in the middle of a conversation); and
b. amnesiac episodes, or continuous disabling drowsiness.

1.1.7 Obstructive Sleep Apnea (OSA)

OSA means a potentially serious disorder in which breathing repeatedly stops and starts during sleep. There are several types of sleep apnea, but the most common is obstructive sleep apnea. (OSA) may be caused by any ~~one~~ONE of the following:

a. Reduced upper airway caliber due to obesity;
b. Adenotonsillar hypertrophy (unusual growth of the adenoid);
c. Mandibular deficiency;
d. Macroglossia (unusually large tongue);
e. Upper airway tumor;
f. Excessive pressure across the collapsible segment of the upper airway; or
g. Activity of the muscles of the upper airway insufficient to maintain patency.

1.1.8 Parasomnia

Parasomnia means a group of conditions that represent undesirable or unpleasant occurrences during sleep. These conditions are ~~may include the following~~:

a. Sleepwalking;
b. Sleep terrors and nightmares;
c. Rapid eye movement (REM) sleep behavior disorders;
d. Confusional arousals; or
e. Recurrent isolated sleep paralysis.

Suspected seizure disorders as possible cause of the parasomnia are appropriately evaluated by standard or prolonged sleep EEG (Electroencephalogram) studies.

A ~~B~~beneficiar~~ies~~y shall ~~should~~ undergo polysomnography in a sleep laboratory when they:

a. are at risk for harming themselves or others,
b. have symptoms referable to other sleep disorders; or
c. are not meeting the criteria for typical parasomnia events.

1.1.9 Periodic Limb Movement Disorder (PLMD)

PLMD means ~~is~~ an involuntary, repetitive movement disorder during sleep, primarily in the legs that may lead to arousals, sleep disruption, and corresponding daytime sleepiness.

1.1.10 Sleep Apnea

Sleep apnea means ~~is~~ a potentially lethal condition where the beneficiary stops breathing during sleep. The three types are:

a. central (absence of respiratory effort),

b. obstructive (occlusion of the airway), and

c. mixed (combination of these factors).

1.1.11 Apnea

Apnea means ~~is defined as~~ a cessation of airflow for at least ten seconds.

1.1.12 Hypopnea

Hypopnea means ~~is defined as~~ an abnormal respiratory event lasting at least ten seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow with at least four percent oxygen desaturations.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid
None Apply.

b. NCHC
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: https://medicaid.ncdhhs.I amgov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

a. Supervised Polysomnography or Sleep Study

Medicaid and NCHC shall cover Sleep Studies and Polysomnography Services when the beneficiary and facility meet the following specific criteria:

1. A supervised polysomnography or sleep study performed in a sleep laboratory may be considered medically necessary as a diagnostic test for a beneficiary who presents with any ~~one~~ ONE of the following:
   A. ~~1.~~ Narcolepsy or Idiopathic Hypersomnolence;
   B. ~~2.~~ Sleep Apnea;
   C. ~~3.~~ Parasomnia;
   D. ~~4.~~ Periodic Limb Movement Disorder (PLMD);
   E. ~~5.~~ Chronic Insomnia;
   F. ~~6.~~ Snoring; or

G. ~~7.~~Congenital or Sleep Related Hypoventilation and Hypoxemia, and

2. Supervised polysomnography services must be provided in a sleep facility (sleep centers with both a clinic and laboratory) that is accredited by The American Academy of Sleep Medicine (AASM), The Joint Commission (Formerly the Joint Commission on Accreditation of Healthcare) or the Accreditation Commission for Health Care (ACHC).

b. Home Sleep Test (HST) or Unattended Sleep Studies

Medicaid and NCHC shall cover Unattended Sleep Studies ~~only~~ ONLY for the diagnosis of OSA, when ALL of the following are met:

1. Type II ~~or~~ Type III or Type IV device is used as described below:
   A. Type II: Comprehensive, portable sleep study Minimum of seven parameters including EEG, EOG, chin EMG, ECG or heart rate, airflow, respiratory effort, oxygen saturation;
   B. Type III: Modified portable sleep apnea testing Minimum of four parameters, including ventilation (at least two channels of respiratory movement, or respiratory movement and airflow), heart rate or ECG, and oxygen saturation); or
   C. Type IV: Monitors and records a minimum of 3 channels that allow direct calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) as the result of measuring airflow or thoracoabdominal movement.

~~2.~~ Service ~~shall~~ must be provided by a physician who meets all eligibility qualifications for participation in **Section 6.0**, ~~and meet the following: The qualifications of the physician who interprets and bills the unattended sleep studies (HST Type II or, III,) must include at least ONE of the following:~~

~~A. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM);~~

~~B. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Me dical Specialties (ABMS);~~

~~C. Completed residency or fellowship training 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 an accredited of a sleep center or laboratory. accredited by the American Academy of Sleep Medicine (AASM), The Joint Commission (Formerly the Joint Commission on Accreditation of Healthcare) or the Accreditation Commission for Health Care (ACHC).~~

3. The test ~~shall~~ must be interpreted by a physician qualified to read full sleep studies.
4. All of the raw data ~~shall~~ must be examined by the reading physician.
5. The test ~~shall~~ must gather a minimum of six hours of data collected during the beneficiary's usual sleeping period.

6. The beneficiary meets the following criteria:

   A. High pretest probability of OSA with at least four (4) of the following symptoms are considered to be at high risk for OSA:
      i. habitual snoring;
      ii. observed apneas;
      iii. wakes choking and gasping for air;
      iv. morning headaches;
      v. excessive daytime sleepiness; and
      vi. a body mass index greater than 35

7. OSA is suspected and in-laboratory PSG is not possible or diagnosis of OSA has been established, therapy has been initiated, and response to treatment is to be evaluated, and no significant co-morbid conditions exist that could impact the accuracy of the study (moderate to severe pulmonary disease, neuromuscular disease, congestive heart failure, brain disease or cognitive impairment) or no sleep disorders other than OSA are suspected (central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders, narcolepsy).

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

3.3 Repeat Polysomnography or HST for Diagnosing Sleep Apnea

Medicaid and NCHC shall cover a repeat polysomnography or HST for diagnosing sleep apnea, when the required documentation to justify the medical necessity for the repeated test is provided, and ONE of the following criteria are met:

a. the first study is technically inadequate due to equipment failure;
b. the beneficiary could not sleep or slept for an insufficient amount of time to allow a clinical diagnosis;
c. the results were inconclusive or ambiguous; or
d. initiation of therapy or confirmation of the efficacy of prescribed therapy is needed.

3.4 Follow-up Polysomnography or HST

Medicaid and NCHC shall cover follow-up polysomnography or HST when ONE of the following criteria are met:

a. After substantial weight loss has occurred in patients on CPAP for treatment of sleep-related breathing disorders to ascertain whether CPAP is still needed at the previously titrated pressure;
b. After substantial weight gain has occurred in patients previously treated with CPAP successfully, who are again symptomatic despite the continued use of CPAP, to ascertain whether pressure adjustments are needed; or
c. When clinical response is insufficient or when symptoms return despite a good initial response to treatment with CPAP.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

a. Medicaid and NCHC shall not cover sleep studies and polysomnography for the following indications:
   1. Impotence.
   2. Chronic insomnia, except when an underlying physiology exists, such as those listed under **Subsection 3.2.1.**
   3. Snoring, except when an underlying physiology exists, such as:
      A. Disturbed sleep patterns;
      B. Excessive daytime sleepiness;
      C. Unexplained awake hypercapnia;
      D. Apneic breathing;
      E. Cognitive problems; or
      F. Excessive fatigue.

b. Medicaid and NCHC shall not cover Unattended (unsupervised) Sleep Studies or Home Sleep Tests (HST) for the following indications:
   1. ~~For a~~ beneficiar~~ies~~sy who is considered at low to moderate risk for OSA;
   2. Unattended sleep studies utilizing fewer than four (4) channels for the diagnosis of sleep apnea syndromes; or
   3. For ~~In~~ a beneficiary under 18 years of age.

c. HST is not covered for patients with certain medical comorbidities, including:
   1. Moderate to severe pulmonary disease (e.g., patients on oxygen or regular bronchodilator use)
   2. Neuromuscular disease affecting muscles of respiration
   3. Congestive heart failure
   4. Suspicion of the presence of other sleep disorders, i.e. narcolepsy, parasomnia, or periodic limb movements of sleep
   5. Other respiratory disorders, impotence, restless legs syndrome.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for unattended (unsupervised) sleep studies. Medical records documenting the criteria listed in **Subsection 3.2.1.b must** be submitted with the request.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.3 Previous Testing

Previous testing performed by the attending physician, to the extent the results are still pertinent, must not be duplicated.

5.4 General Requirements

Sleep studies and polysomnography must consist of recording, interpretation, and reporting.

5.5 Polysomnography Requirements

For a study to be reported as polysomnography, sleep must be recorded and staged. Sleep staging includes, but is not limited to:

a. 1- to 4-lead electroencephalogram (EEG);
b. Electro-oculogram (EOG);
c. Submental electromyogram (EMG);

d. Electrocardiogram (EKG);
e. Airflow, ventilation, and respiratory effort;
f. Oximetry and/or CO2 measurements;
g. Extremity muscle activity;
h. Extended EEG monitoring;
i. Gastroesophageal reflux;
j. Continuous blood pressure monitoring;
k. Habitual Snoring; or
l. Body positions.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Service ~~shall~~ must be provided by a physician who meets all eligibility qualifications for participation in **Section 6.0**, and meet the following:

The qualifications of the physician who interprets and bills the unattended sleep studies (HST-Type II or, III,) must include at least ONE of the following:

E. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM);
F. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS);
G. Completed residency or fellowship training 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
H. Active staff membership of an accredited ~~of a~~ sleep center or laboratory. ~~accredited by the American Academy of Sleep Medicine (AASM), The Joint Commission (Formerly the Joint Commission on Accreditation of Healthcare) or the Accreditation Commission for Health Care (ACHC).~~

~~None Apply~~.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Documentation

a. In order to perform the technical component (TC) of PSG and sleep testing (including HST), the following must be met:
b. The sleep center or laboratory must maintain documentation on file that indicates it is accredited by either:

1. the American Academy of Sleep Medicine (AASM);
2. the Accreditation Commission for Health Care (ACHC); or
3. the Ambulatory Care Accreditation Program of the Joint Commission;

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1991
Revision Information:

Date	Section Revised	Change
12/01/2006	Sections 2 through 5	A special provision related to EPSDT was added.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
05/01/2007	Attachment A	Added UB-04 as an accepted claim form
09/01/2007	All sections and attachment(s)	Standardized requirements language.
09/01/2007	Section 5.1	Added statement that prior approval is not required.
09/01/2007	Attachment A, letter A	Added electronic transaction numbers.
09/01/2007	Attachment A, letter B	Removed general ICD-9-CM code 799.0 and added more specific codes 799.01 and 799.02.
09/01/2008	Section 3.2.6	Added criteria for snoring to be used as medical necessity for a sleep study.
09/01/2008	Section 4.2	Clarified that snoring must be accompanied by an underlying physiology in order to be used as a reason for a sleep study.
09/01/2008	Attachment A, letter B	Added diagnosis codes 327.23, 327.51, and 786.09.
07/01/2010	All sections and attachment(s)	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to DMA in the NC Department of Health and Human Services.
03/12/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1A-20 under Session Law 2011-145, § 10.41.(b)
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
02/01/2013	Section 3.2b	Added criteria for unattended sleep studies
02/01/2013	Section 4.2b	Clarified what was not covered for unattended sleep studies
02/01/2013	Section 5.1	Added PA criteria for unattended sleep studies
02/01/2013	Attachment A, letter C	Added CPT code for unattended sleep studies
02/01/2013	All sections and attachment(s)	Technical changes updating beneficiary language
04/01/2013	Attachment A, letter C	The American Medical Association (AMA) added new CPT codes 95782 and 95783and amended 95808, 95810 and 95811 effective with date of service January 1, 2013
05/07/2013	Attachment A, letter C	Removed yellow highlighting
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."

03/15/2019	All Sections and Attachments	Updated policy template language.
12/01/2019	Section 1.0	Description replaced. Polysomnography, (PSG) and sleep study definitions combined.
12/01/2019	Section 1.1	Removed definitions of Polysomnography and Sleep Study.
12/01/2019	Section 1.1.1	Moved terms with definitions from 3.2.1.a for Narcolepsy, Sleep Apnea, Parasomnia, Periodic Limb Movement Disorder (PLMD) and Chronic Insomnia.
12/01/2019	Section 1.1.1	Defined Chronic Insomnia.
12/01/2019	Section 1.1.2	Defined Home Sleep Test (HST) or Unattended Sleep Study.
12/01/2019	Section 1.1.3	Defined Hypoventilation.
12/01/2019	Section 1.1.4	Added: The Maintenance of Wakefulness Test (MWT) means a test used to measure alertness during the day. It shows whether or not someone is able to stay awake for a defined period of time. This is an indicator of their ability to function and remain alert in quiet times of inactivity.
12/01/2019	Section 1.1.5	Redefined Multiple Sleep Latency Test.
12/01/2019	Section 1.1.6	Added Narcolepsy and Idiopathic Hypersomnolence definition and symptoms.
12/01/2019	Section 1.1.7	Added Obstructive Sleep Apnea (OSA) definition and causes
12/01/2019	Section 1.1.8	Added: b. Sleep terrors and nightmares, d. Confusional arousals, and e. Recurrent isolated sleep paralysis. Added: Beneficiaries should undergo polysomnography in a sleep laboratory if they are at risk for harming themselves or others, have symptoms referable to other sleep disorders or are not meeting the criteria for typical parasomnia events.
12/01/2019	Section 1.1.10	Defined types of Sleep Apnea: absence (absence of respiratory effort), obstructive (occlusion of the airway), and mixed (combination of these factors).
12/01/2019	Section 3.2.1(a)	Removed definitions under 1. Narcolepsy, 2. Sleep Apnea, 3. Parasomnia, 4. Periodic Limb Disorder (PLMD), 5. Chronic Insomnia, 6. Snoring and added 7. Congenital or Sleep Related Hypoventilation and Hypoxemia. Also added or Idiopathic Hypersomnolence to 1. Narcolepsy.
12/01/2019	Section 3.2.1(b)	Added Home Sleep Test (HST) to Unattended Sleep Studies and clarified that Unattended Sleep Studies are covered only for the diagnosis of OSA and when all of the specified criteria are met.
12/01/2019	Section 3.2.1(b)2. (D)	Added or the Accreditation Commission for Health Care (ACHC).
12/01/2019	Section 3.2.1(b) 7.	Added brain disease or cognitive impairment.

12/01/2019	Section 4.2.1	Deleted "as they are not considered medically necessary."
12/01/2019	Section 4.2.1(c)	Replaced "those listed under **Subsection 3.2.1,"** with: a. Disturbed sleep patterns, b. Excessive daytime sleepiness, c. Unexplained awake hypercapnia, Apneic breathing, d. Cognitive problems, e. Excessive fatigue.
12/01/2019	Attachment A. (B)	ICD 10-CM Code(s) Removed
12/01/2019	Attachment A. (F)	Added Independent Diagnostic Treatment Facility (IDTF)
12/01/2019	Attachment A	Updated policy template language "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
12/01/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
	All Sections and Attachments	Updated
	Section 1.0	Added the term sleep studies. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging.
	Section 1.0	Added that in addition to helping diagnose sleep disorders, polysomnography may be used to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP) and deleted to help adjust treatment plans, if a diagnosis of a sleep disorder has been made.
	Section 3.2.1 (a)(2)	Moved from 3.2.1.(b)(2)(D)Supervised polysomnography services must be provided in a sleep facility (sleep centers with both a clinic and laboratory) that is accredited by The American Academy of Sleep Medicine (AASM), The Joint Commission (Formerly the Joint Commission on Accreditation of Healthcare) or the Accreditation Commission for Health Care (ACHC).
	Section 3.2.1 (b) (C)	Defined a Type IV device
	Section 3.2.1 (b) 2.	Moved physician qualifications to section 6.1
	Section 3.3 and 3.4	Added section 3.3 and 3.4 Repeat Polysomnography or HST for Diagnosing Sleep Apnea, and Follow-up Polysomnography or HST

	Section 4.2.1(c)	Added list of Medical comorbidities that are not covered for HST
	Section 7.2	Added section 7.2 Documentation
	Attachment A. (C)	Added CPT code 95800
	Attachment A. (E) 2.	Added 95800 to Polysomnography codes

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Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for a code, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s)
95800
95805
95806
95807
95808
95810
95811
95782
95783

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

The provider shall report the appropriate procedure code(s) used which determines the billing unit(s).

1. Polysomnography and sleep studies may be billed as a complete procedure or as professional and technical components.
   a. Polysomnography and sleep studies are limited to one procedure per date of service by the same or different provider.
   b. The technical or the professional component cannot be billed by the same or different provider on the same date of service as the complete procedure is billed.
   c. The complete procedure is viewed as an episode of care that may start on one day and conclude on the next day. When billing for the complete procedure, the date that the procedure began is the date of service that ~~should~~ must be billed. The complete procedure ~~should~~ must not be billed with two dates of service.
   d. If components are billed, the technical and the professional components ~~should~~ must be billed with the date the service was rendered as the date of service.
2. Separate reimbursement is not allowed for the following procedures on the same date of service by the same or different provider:
   a. Electrocardiographic monitoring for 24 hours (CPT codes 93224 through 93272) with sleep studies and polysomnography (CPT codes 95800~~95805~~ through 95811).
   b. Non-invasive ear or pulse oximetry single or multiple determinations (CPT codes 94760 and 94761) with sleep studies and polysomnography (CPT codes 95800~~95805~~ through 95811).
   c. Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour, continuous recording, infant, (CPT code 94772) with sleep studies (CPT codes 95800~~95805~~ through 95806) (age six and under).
   d. Continuous positive airway pressure ventilation, CPAP, initiation and management, (CPT code 94660) with polysomnography (CPT code 95800 through 95811).
   e. Electroencephalogram (CPT codes 95812 through 95827) with polysomnography (CPT codes 95800~~95808~~ through 95811).
   f. Facial nerve function studies (CPT code 92516) with polysomnography (CPT codes 95800~~95808~~ through 95811).

F. Place of Service

Inpatient hospital, Outpatient hospital, Physician's office, Independent Diagnostic Treatment Facility (IDTF), home.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/