Clinical Policy: Home Sleep Testing

Reference Number: CP.MP.75
Effective Date: 02/15
Last Review Date: 02/17

Coding Implications
Revision Log

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

Description

Medical necessity criteria for home sleep testing (HST), also referred to as unattended portable monitoring and out-of-center sleep testing, for the diagnosis of obstructive sleep apnea (OSA) in adulthood**.** HST is a diagnostic tool that can be used to diagnose simple OSA. It can be used as an alternative to an in-facility, overnight, attended polysomnogram (PSG) in members with a high probability for moderate to severe OSA.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that *initial HST* performed with a Type 2 or Type 3 device is **medically necessary** when meeting the following criteria:

A. Performed in conjunction with a comprehensive sleep evaluation;
B. Sleep center performing the test is accredited by AASM or Joint Commission;
C. Age ≥ 18 and ≤ 65 years;
D. High pretest probability of moderate to severe OSA, as indicated by excessive daytime sleepiness which impacts daily activities that is not explained by other factors (e.g., medication, drugs, alcohol, psychiatric disorder) and at least one other factor:
    1. Witnessed apnea;
    2. Sleep-disruptive snoring;
    3. Gasping or snorting while sleeping;
    4. Obesity (BMI ≥30 kg/m^2) or increased neck circumference (>17 inches men, >16 inches women);
E. Has none of the following contraindications to HST:
    1. Moderate to severe pulmonary disease (e.g., COPD with class III or IV heart failure,[4] asthma, O_2 dependent);
    2. Neuromuscular disease;
    3. Congestive heart failure;
    4. Hypoventilation syndromes; [4]
    5. Suspected or diagnosed central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders, or narcolepsy;
    6. Physical or cognitive inability to appropriately use the equipment or does not have someone able to assist with the equipment;
    7. Previous technically suboptimal home sleep study.

II. *Follow up HST* performed with a Type 2 or Type 3 device is medically necessary when meeting the following criteria:

A. For assessment of one of the following:
    1. Effectiveness of surgery or oral appliances or devices (i.e., CPAP/BiPAP); or

2. Re-evaluate the diagnosis of OSA and the need for continuing a device following significant weight loss (loss of ≥ 10% of body weight) since the most recent study.

B. Has none of the following contraindications to HST:
   1. Moderate to severe pulmonary disease (e.g., COPD, asthma, oxygen-dependence);
   2. Neuromuscular disease;
   3. Congestive heart failure;
   4. Suspected or diagnosed central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders, or narcolepsy;
   5. Physical or cognitive inability to appropriately use the equipment or does not have someone able to assist with the equipment;
   6. Previous technically suboptimal home sleep study.

III. HST is considered **not medically necessary** when performed with a Type 4 device or for any other indications not listed above.

Background

Polysomnography (PSG) is the most commonly used test in the diagnosis of specific sleep disorders, primarily OSA. Monitoring typically includes activity of the brain, chin, eyes, chest wall, and limbs; heart rate and rhythm; airflow through the nose and mouth; oxygen saturation; snoring loudness; sleep position; and fragmentation of sleep.

There are four types of monitoring devices which may be used for sleep studies. Type 1 devices are used in the sleep center, technician attended, for an overnight PSG. Type 2 devices can record the same variables as type 1 devices but can also be used outside of a sleep center and do not require a technician to be present. Type 3 devices measure between four and seven physiologic parameters, including two respiratory variables, a cardiac variable, and oxygen saturation by pulse oximetry. Measurement of these variables generally provides adequate information for the evaluation of most sleep apneas. Type 4 devices differ by definition and may only record one to 3 variables. Generally, Type 4 devices provide insufficient data for an accurate diagnosis of OSA.[4]

Portable monitoring is a more convenient and lower cost tool for diagnosing OSA in those members who are highly suspected of having moderate to severe OSA. Advantages include that the members are able to perform the test in the comfort of their own homes, the HST system is less costly than the complete PSG system, and a technician is not required for completion of the test. Fewer physiologic variables are measured with HST in comparison with PSG, however, so proper patient selection is necessary to take full advantage of the value of this technology. The Portable Monitoring Task Force of the American Academy of Sleep Medicine (AASM) recommends portable monitoring for the diagnosis of OSA in conjunction with a comprehensive sleep evaluation (2007). [5]

Furthermore, several studies have established HST as being similar to PSG in the diagnosis and treatment of OSA. Rosen and colleagues conducted a large, multisite randomized trial of lab-based PSG versus HST (2012). They found that HST performed similarly to PSG for diagnosis and treatment of patients with moderate to severe OSA, and that it was well-accepted by patients (Rosen et al., 2012). These findings are consistent with multiple other studies conducted in a

similar fashion by Whitelaw, et al. (2005), Mulgrew, et al. (2007), Berry, et al. (2008), and Skomro, et al. (2010). Most studies on HST included subjects who were under 65 and over 18 and who did not have significant comorbidities (Collop, et al., 2007, p. 740). [1 5 8 9 10 11]

For HST, the AASM stipulates that an experienced sleep technician, sleep technologist, or appropriately-trained healthcare practitioner must apply HST sensors or directly educate the patient in the correct application of sensors. [5]

Per the AASM, HST should not be used in patients who have comorbid medical conditions that predispose to sleep-related breathing disorders. This includes patients with significant respiratory disease such as chronic obstructive pulmonary disease (COPD) patients with class III or IV heart failure (because they are predisposed to Cheyne-Stokes breathing), and patients with hypoventilation syndromes. [4]

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 2015, 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	Description
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (e.g., by airflow or peripheral arterial tone)
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)

HCPCS Codes	Description
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

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Codes	Description
E66.9	Obesity, unspecified
G47.00	Insomnia, unspecified
G47.30	Sleep apnea, unspecified
G47.33	Obstructive sleep apnea (adult) (pediatric)
G47.9	Sleep disorder, unspecified
R06.83	Snoring

Reviews, Revisions, and Approvals	Date	Approval Date
Reviewed by IM and PUD specialists Policy developed		2/15
Updated template References reviewed and updated Background information added regarding who should apply HST sensors.	2/16	2/16
Updated template References reviewed and updated ICD-10 CM Diagnosis Codes added Background information added regarding HST with comorbid conditions	2/17	2/17

References

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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. This clinical policy is not intended to recommend treatment for members. Members 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, 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, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and 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.