Split Night Sleep Study

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below

Policy Overview

Affected CPT codes: 95810, 95811

CPT codes 95810 and 95811 are considered mutually exclusive procedures when billed together on the same night, according to both the American Medical Association (AMA) and NCCI Procedure to Procedure Edits. It is not permissible to bill the diagnostic portion and titration portion of a sleep study separately.

For billing purposes related to a **diagnostic sleep study only**, the appropriate CPT code to utilize is **95810**.
95811 or As reiterated, CPT codes 95810 and 95811 are mutually exclusive if billed together on the same night, in line with AMA and NCCI guidelines.

The American Academy of Sleep Medicine has clarified that the diagnostic and titration portions of a sleep study should not be billed separately. For a split night study and a PAP titration study, CPT code 95811 is the correct code to use.

According to CMS, providers *can* conduct diagnostic and titration services in two separate visits or combine them into a single visit (split night). However, if the service is performed across two visits, the proper coding procedure involves billing only for CPT code 95811.

Procedure Codes (CPT & HCPCS)

Code	Code Description
95810	Polysomnography: age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811	Polysomnography: age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

Documentation History

Type	Date	Action
Effective Date		New Policy
Revised Date	8/16/23	Verified links, updated page numbers for links- CS
Revised Date	12/13/2024	Updated Template

References

Government Agencies

CMS-

Local Coverage Determinations (LCD) L35050: Outpatient Sleep Studies

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35050
"For patients with severe and unambiguous obstructive sleep apnea, the initiation of treatment with nasal CPAP may be incorporated into the diagnostic study night. This is called a "split-night" study (initial diagnostic polysomnogram followed by CPAP titration during polysomnography on the same night). A split night study is an overnight polysomnogram in which the patient spends the first half of the night being monitored for sleep apnea. This approach may be an alternative to one full night of diagnostic polysomnography followed by a second night of titration as long as: CPAP titration is carried out for more than 3 hours; and Polysomnography documents that CPAP eliminates or nearly eliminates the respiratory events during REM and NREM sleep. ***Page 7.***

Local Coverage Determinations (LCD) L36861: Polysomnography and Other Sleep Studies

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36861&ver=15&Date=&DocID=L36861&SearchType=Advanced&bc=FAAAAAgAAAAA&

"For Continuous Positive Airway Pressure (CPAP) titration, a split-night study (initial diagnostic polysomnogram followed by CPAP titration during polysomnography on the same night) is an alternative to one full night of diagnostic polysomnography, followed by a second night of titration for the treatment of obstructive sleep apnea (OSA) if the following criteria are met:

A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) are met:

- AHI or RDI greater than or equal to 15 events per hour with a minimum of 30 events.
- Or AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and 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 RDI is equal to the average number of respiratory disturbances per hour.

If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.

- CPAP titration is carried out for more than three hours; **and**

- Polysomnography documents that CPAP eliminates, or nearly eliminates, the respiratory events during REM and NREM sleep. ***Page 6***.

Medicare Benefit Policy Manual: Chapter 15 – Covered Medical and Other Health Services

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Medicare Benefit Policy Manual (Chapter 15-Covered Medical and Other Health Services)

"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. Ordinarily, a single polysomnogram and electroencephalogram (EEG) can diagnose sleep apnea. If more than one such testing session is claimed, the A/B MAC (B) will require persuasive medical evidence justifying the medical necessity for the additional tests. It will use HCPCS procedure codes 95807,

95810, and 95822. ***Page 93.***

Government Agencies Continued:

DHHS/OIG-

Department of Health and Human Services; Office of Inspector General

https://oig.hhs.gov/oei/reports/oei-05-12-00340.pdf

Executive Summary: Questionable Billing for Polysomnography Services, OEI-05-12-00340

"Providers can perform diagnostic and titration services in two visits or together in a single visit, known as a split-night service. Providers can perform a split-night service when a diagnosis of sleep apnea can be made within the first few hours of the polysomnography service and the provider is able to fit and titrate the PAP device in the same night. If the provider cannot make a diagnosis early in the polysomnography service, the beneficiary may need to return at a later date for an additional polysomnography service to fit and titrate the PAP device." Page 2

"Several LCDs for polysomnography specify that one service is usually sufficient for diagnosis and titration. These LCDs note that there are some instances in which beneficiaries may need to return for repeat polysomnography services (e.g., in the case of equipment failure, inconclusive results, or titration adjustments). However, the LCDs specify that routinely performing repeat services is not medically necessary, and that providers must have persuasive documentation to justify the necessity of repeat tests. Providers billing for polysomnography services using three CPT code. Providers bill for diagnostic services using either CPT code 95808 or 95810, depending on how many parameters of sleep are measured. Providers bill for both full-night titration services and split-night services using CPT code 95811." Page 3

Professional Society Guidelines and Other Publications

AASM-

American Academy of Sleep Medicine (AASM)

https://aasm.org/clinical-resources/coding-reimbursement/coding-faq/ (Member only resource)

"There is no separate CPT code for a split- night study code. Code 95811 is the appropriate code for both a split-night study and a PAP titration study. The descriptor of code 95811 matches both types of studies. It is not appropriate to bill the diagnostic portion and titration portion of a study separately. Doing so would be billing for two procedures when only one was performed. The AASM clinical practice guideline on diagnostic testing for Adult OSA recommends a minimum of two hours of diagnostic recording and three hours of recording for CPAP titration."

Other Reviewed Publications

Molina Clinical Policy-

Molina Clinical Policy MCG-159 Split Night Sleep Studies for CPAP Titration for Obstructive Sleep Apnea Syndrome

Split-Night-Sleep-Studies-for-OSA-MCG-159.pdf (molinahealthcare.com)

"Molina Healthcare considers a split-night in-laboratory polysomnography as a first line diagnostic test to be the preferred alternative to a two-night polysomnography test. Page 2.

"A second full night PSG should be performed for titration of positive airway pressure when both of the following criteria are met:

- The split night study is not able to conduct PAP titration over > or equal to 3 hours; and
- PAP has not been documented to eliminate or nearly eliminate respiratory events during REM and NREM sleep including during supine REM sleep Page 3.

State Medicaid-

California: Silent

Florida: Silent

Illinois: Silent

Kentucky: **No data*

New York: Silent

Michigan: Silent

Mississippi: Silent

Ohio: Silent

South Carolina: Silent

State Medicaid Continued:

Texas: https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/archives/2020-01-TMPPM.pdf

"Polysomnography (procedure codes 95782, 95783, 95808, 95810, and 95811) is limited to one per day

and two per rolling year by any provider." Section 9.2.68.3 -Page 212.

Utah: https://medicaid.utah.gov/Documents/criteria/pdfs/Polysomnogram._Adult_Pediatric.pdf

"Utah Medicaid will reimburse for 1-PSG 95810 and 1-PSG 95811 per calendar year without prior authorization. Requests that exceed the limit of (1) code per year require prior authorization and must meet UDOH criteria."

Page 1

Washington: Silent

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed