Cohere Medicare Advantage Policy - Sleep Study/Polysomnography (PSG)

Clinical Guidelines for Medical Necessity Review

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Important Notices

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Guideline Information:

Specialty Area: Sleep Medicine
Guideline Name: Cohere Medicare Advantage Policy - Sleep Study/Polysomnography (PSG)
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Sleep Study/Polysomnography (PSG)

Related CMS Documents

Please refer to the CMS Medicare Coverage Database for the most current applicable CMS National Coverage.[1-14]

- National Coverage Determination (NCD). Continuous positive airway pressure (CPAP) therapy for obstructive sleep apnea (OSA) (240.4)
- National Coverage Determination (NCD). Sleep testing for obstructive sleep apnea (OSA) (240.4.1)
- Local Coverage Determination (LCD). Polysomnography and other sleep testing (L33405)
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Description

Sleep study/polysomnography (PSG) is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters during sleep (e.g., brain waves, blood oxygen level, heart rate, breathing rate, and eye and leg movements) for 6 hours or more, together with the review and interpretation of the records by a physician. Results are reviewed and interpreted by a physician. A comprehensive sleep evaluation must include a sleep history (e.g., snoring, apneas, daytime sleepiness), body mass index (BMI), neck circumference, cardiopulmonary examination, and identification of co-morbid sleep disorders and medical conditions.

Sleep study/PSG is performed to diagnose various sleep disorders. The gold standard for diagnosing obstructive sleep apnea (OSA) is overnight or split-night technologist-attended facility-based PSG. Split-night studies are performed to diagnose strongly suspected OSA and evaluate response to continuous positive airway pressure (CPAP) treatment over a one-night period[1]. Completing the CPAP titration study on a second night may be appropriate. Two tests may be used in addition to PSG testing. Multiple sleep latency tests (MSLT) measure daytime sleepiness and aid in diagnosing types 1 and 2 narcolepsy and idiopathic hypersomnia. Maintenance of wakefulness tests (MWTs) measures the ability to stay awake.[15]

Sleep studies are performed in settings that include hospitals and outpatient sleep laboratories (accredited by the American Academy of Sleep Medicine, Accreditation Commission for Health Care, or The Joint Commission) as well as in the patient's home. Providers should hold certification or accreditation from any of the following organizations[3,7,16]:

- Diplomate of the American Board of Sleep Medicine (ABSM)
- Sleep certification from the following:
  - American Board of Internal Medicine (ABIM)
  - American Board of Family Medicine (ABFM)
  - American Board of Pediatrics (ABP)
  - American Board of Psychiatry and Neurology (ABPN)
  - American Board of Otolaryngology (ABOto)
  - American Osteopathic Board of Neurology and Psychiatry (AOBNP)
  - American Osteopathic Board of Family Medicine, (AOBFP)
  - American Osteopathic Board of Internal Medicine, (AOBIM)

    - American Osteopathic Board of Ophthalmology and Otorhinolaryngology (AOBOO)
- Physician staff member of a credentialed sleep center or laboratory that has active physician staff members meeting the physician credential criteria above.

Sleep technicians performing services should meet the requirements of the following organizations:

- American Board of Sleep Medicine (ABSM) (e.g., Registered Sleep Technologist [RST])
- Board of Registered Polysomnographic Technologists (BRPT) (e.g., Registered Polysomnographic Technologist [RPSGT])
- National Board for Respiratory Care (NBRC) (e.g., Certified Pulmonary Function Technologist [CPFT], Registered Pulmonary Function Technologist [RPFT], Certified Respiratory Therapist [CRT], Registered Respiratory Therapist [RRT]).

Medical Necessity Criteria

Indications

A **sleep study**[A] is considered appropriate if **ANY** of the following is **TRUE**[17]:

- **Home-based, non-attended sleep study** with **ANY** of the following:
    - For an initial home study when the patient is an adult with clinical signs and symptoms of OSA[B]; **OR**
    - Repeat home study and **ANY** of the following[3,17-18]:
        - The first study was inconclusive due to technical or equipment failure; **OR**
        - The patient is unable to sleep or complete enough hours of sleep to allow a clinical diagnosis; **OR**
        - The results were inconclusive or ambiguous; **OR**
        - For re-evaluation due to weight change; **OR**
- **Facility-based, technologist-attended PSG (Type I)** with **ANY** of the following:
    - For an initial facility-based study when the patient is an adult with clinical signs and symptoms of OSA[B]; **OR**
    - **ANY** of the following are suspected with planned multiple sleep latency testing (MSLT)[15]:
        - Narcolepsy with **ANY** of the following:
            - Cataplexy; **OR**

        - Excessive daytime sleepiness; **OR**
        - Hallucinations with the onset of sleep or awakening; **OR**
        - Disrupted nighttime sleep; **OR**
        - Sleep paralysis; **OR**
    - Central disorders of hypersomnia with **ANY** of the following:
        - Sleep inertia; **OR**
        - Unrefreshed sleep with adequate or long sleep time; **OR**
- An in-laboratory sleep study is needed when a home sleep study cannot be performed with **ANY** of the following[19]:
    - Obesity hypoventilation syndrome (defined as a body mass index [BMI] greater than 30, daytime hypercapnia [partial pressure of carbon dioxide, $PaCO_2$, greater than 45 mm Hg without other causes such as kyphosis, myopathy, hypothyroidism, or lung disease]); **OR**
    - Awake daytime hypercapnia (partial pressure of carbon dioxide, $PaCO_2$, greater than or equal to 45 mm Hg without other causes such as kyphosis, myopathy, hypothyroidism, or lung disease - serum bicarbonate greater than 28 is considered an alternative in the absence of $PaCO_2$ from arterial blood gases); **OR**
- Suspected central sleep apnea (CSA); **OR**
- Evaluation of parasomnias (e.g., undesirable or unpleasant occurrences during sleep, sleepwalking, sleep terrors, rapid eye movement, sleep behavior disorder[20], history of repeated violent or injurious episodes during sleep) with **ANY** of the following[3,7]:
    - The patient has a history of parasomniac episodes during sleep that result in harm to the patient or others; **OR**
    - To assist with the diagnosis of paroxysmal arousals or other sleep disruptions that are thought to be seizure-related when the initial clinical evaluation and results of a standard EEG are inconclusive; **OR**
    - To evaluate sleep-related behaviors that are violent or otherwise potentially injurious to the patient; **OR**
    - The patient has a sleep behavior suggestive of parasomnias that are unusual or atypical due to **ALL** of the following:
        - Age at onset; **AND**
        - Time, duration, or frequency of occurrence of the behavior; **AND**
        - Specifics of the particular motor patterns are in question (e.g., stereotypical, repetitive, or focal); **OR**

        - In situations with forensic considerations (e.g., if onset follows trauma or if the events themselves have been associated with personal injury); **OR**
        - When the presumed parasomnia or sleep-related epilepsy does not respond to conventional therapy; **OR**
        - In cases of typical, uncomplicated, and non-injurious parasomnias when the diagnosis is not clearly delineated; **OR**
    - The pediatric patient has suspected sleep apnea with an initial PSG test indicated by **ANY** of the following[16,21-22]:
        - Evaluation for obstructive sleep apnea (OSA) pre- or post-removal of enlarged tonsils or adenoids; **OR**
        - Down syndrome; **OR**
        - Chiari malformation; **OR**
        - Craniofacial malformation; **OR**
        - Neuromuscular disorder; **OR**
        - Skeletal dysplasia (e.g., achondroplasia); **OR**
        - Suspected periodic limb movement disorder[23]; **OR**
        - Signs and symptoms of OSA with **ANY** of the following:
            - Snoring; **OR**
            - Daytime sleepiness; **OR**
            - Mouth breathing; **OR**
            - Nocturnal apnea; **OR**
            - Enuresis; **OR**
            - Pulmonary hypertension; **OR**
            - Nasal flaring or other signs of breathing difficulty; **OR**
            - Failure to thrive (weight less than 5th percentile for age); **OR**
            - Hyponasal speech; **OR**
            - Behavioral problems (e.g., hyperactivity, developmental delay, difficulties in school); **OR**
    - An attended, full-night titration study including **ALL** of the following:
        - Unattended auto-titration with APAP or auto bi-level PAP is contraindicated; **AND**
        - OSA with **ANY** of the following:
            - Apnea/hypopnea index (AHI), respiratory disturbance index (RDI), or respiratory event index (REI) greater than or equal to 15 events per hour; **OR**
            - AHI, RDI, or REI greater than or equal to 5-14 events per hour with **ANY** of the following:

    - Excessive daytime sleepiness; **OR**
    - Insomnia; **OR**
    - Mood disorders (e.g., anxiety, depression); **OR**
    - Impaired cognition; **OR**
    - History of stroke; **OR**
    - Hypertension; **OR**
    - Ischemic heart disease; **AND**
- **ANY** of the following:
  - The patient has **ANY** of the following co-morbid conditions:
    - Heart failure with New York Heart Association (NYHA) Classification III or IV or reduced ejection fraction less than or equal to 40%; **OR**
    - Cardiac arrhythmia(s) (acute, uncontrolled, or refractory) with documented symptoms; **OR**
    - Severe asthma with daily use of oral corticosteroids and/or immunomodulator biologics; **OR**
    - Pulmonary disease (e.g., moderate to severe COPD or interstitial lung disease) as diagnosed on pulmonary function studies (PFTs) and the patient requires chronic oxygen use; **OR**
    - Obesity hypoventilation syndrome (OHS); **OR**
    - Moderate to severe pulmonary hypertension; **OR**
    - Neuromuscular/neurodegenerative disorders with restrictive disease or hypoventilation (e.g., amyotrophic lateral sclerosis [ALS], post-polio syndrome, myasthenia gravis, Guillian-Barré syndrome, polymyositis, kyphoscoliosis); **OR**
    - Chronic opioid medication use; **OR**
  - The patient has a second or associated sleep disorder other than OSA, including **ANY** of the following:
    - Central nervous system disorders that increase the risk of CSA (e.g., Arnold Chiari malformation); **OR**
    - CSA or treatment-emergent sleep apnea; **OR**
    - Acute nocturnal seizures; **OR**
    - Narcolepsy or related symptoms following the evaluation and treatment of OSA in accordance with the patient's documented adherence to therapy; **OR**
    - Complex parasomnias that may include injurious, disruptive, or violent behavior (e.g., sleepwalking, REM behavior disorder); **OR**

        - Periodic limb movement disorder (PLMD); **OR**
    - The patient failed a recent home APAP trial due to **ANY** of the following:
        - Auto bi-level therapy is contraindicated or was ineffective; **OR**
        - PAP therapy was not tolerated after a trial of at least 1 month with no previous attended titration; **OR**
        - Adequate objective adherence to therapy (greater than or equal to 4 hours per night for at least 70% of nights in a 30-day consecutive period as documented by APAP download) with **ANY** of the following:
            - Symptoms of residual excessive daytime sleepiness; **OR**
            - Residual AHI greater than or equal to 5 as evidenced by APAP download; **OR**
- Split-night protocol for strong pre-test suspicion of OSA with the initiation of treatment with a positive pressure device, including **ANY** of the following[2,13,17]:
    - For initial testing when the patient is an adult with clinical signs and symptoms of OSA (e.g., snoring loudly, daytime sleepiness, observed sleep apnea [gasping, choking, or breathing that has stopped]); **OR**
    - For repeat split-night testing with **ANY** of the following:
        - The patient has **ANY** of the following:
            - Symptoms of OSA that persist or recur despite PAP therapy; **OR**
            - A change in weight (gain or loss greater than or equal to 10% of total body weight) when OSA symptoms have worsened or improved and re-evaluation is required to determine needed therapy modifications; **OR**
            - A change in cardiovascular status (e.g., stroke, arrhythmia, uncontrolled hypertension, hospitalization for heart failure; **OR**
        - To re-evaluate the indicators of OSA after **ANY** of the following:
            - Adenoidectomy; **OR**
            - Tonsillectomy; **OR**
            - Maxillomandibular advancement surgery (MMA); **OR**
            - Uvulopalatoplasty (UPPP); **OR**
            - Other surgery related to the upper airway; **OR**
        - A non-diagnostic home sleep apnea test (HSAT) performed no more than one year prior with **ANY** of the following:
            - An OSA diagnosis was not determined when there was a high pretest probability of OSA; **OR**

        - An effort was made to perform the test again if the original test was determined to be technically inadequate; **OR**
      - The patient requires evaluation to begin using a fabricated oral mandibular advancement appliance (OAT); **OR**
  - Repeat PSG test, as indicated by **ANY** of the following:
    - Confirmation of the efficacy of prescribed therapy is needed (e.g., oral appliance, postoperative assessment of response to intervention)[13]; **OR**
    - To ascertain whether CPAP is still needed at the previously titrated pressure if the patient experiences substantial weight gain or weight loss on CPAP for the treatment of sleep-related breathing disorders[13]; **OR**
    - The patient shows insufficient clinical response or symptoms return despite a good initial response to CPAP[13]; **OR**
    - Assessing treatment response after upper airway surgical procedures, or initial treatment with oral appliances for **ANY** of the following[13,24-25]:
      - Initial treatment with oral appliances (pre-implantation or re-evaluation of known OSA) with **ANY** of the following:
        - PAP failure or PAP intolerance with BMI less than or equal to 35 with no recent sleep study; **OR**
        - A significant change in weight and/or symptoms; **OR**
      - After upper airway surgical procedures (post-implantation) with **ANY** of the following:
        - Initial PSG titration; **OR**
        - PSG titration previously performed with insufficient clinical response, weight gain and/or return of symptoms; **OR**
  - Multiple sleep latency test (MSLT) performed in a sleep laboratory for **ANY** of the following[15]:
    - For initial MSLT with **ALL** of the following:
      - Evaluation of presence or treatment response for features of **ANY** of the following:
        - Central disorders of hypersomnia; **OR**
        - Narcolepsy (including, cataplexy, EDS, sleep paralysis, hypersomnia); **AND**
      - Testing consists of 5 episodes of 20-minute nap trials at 2-hour intervals, measuring the onset of sleep and rapid eye movement

(REM) sleep, immediately following a negative PSG when narcolepsy is suspected; **OR**
    - Repeat MSLT may be required if initial results are indeterminate or negative when narcolepsy is suspected; **OR**
  - Maintenance of wakefulness tests (MWT) performed in a sleep laboratory are considered appropriate with **ANY** of the following:
    - For initial MWT with **ALL** of the following[26]:
      - To assess an individual's ability to remain awake when his or her inability to remain awake constitutes a public or personal safety issue; **AND**
      - To assess response to treatment and the patient has excessive daytime sleepiness; **OR**
    - Repeat MWT may be required if initial results are indeterminate or negative when symptoms persist.

Non-Indications

A sleep study/polysomnogram is not considered appropriate if **ANY** of the following is **TRUE**:

- Attended full-channel polysomnography or home sleep testing for evaluating **ANY** of the following conditions:
  - Circadian rhythm disorders; **OR**
  - Depression; **OR**
  - Insomnia; **OR**
- Actigraphy for any sleep disorder; **OR**
- Daytime sleep studies for **ANY** of the following:
  - MWT is unproven and not medically necessary in children and adolescents less than 18 years of age; **OR**
  - Abbreviated daytime sleep studies (e.g., PAP-Nap) are not medically necessary due to insufficient evidence of efficacy.

Definitions

[A]**The sleep study/polysomnography** includes the following[3,7,13,16]:

- A 1-4 lead electroencephalogram (EEG) to measure global neural encephalographic activity using electrodes placed on the scalp
- Electrooculogram (EOG) to measure eye movements using electrodes placed near the outer canthus of each eye
- A submental electromyogram (EMG) to measure submental electromyographic activity using electrodes placed over the mentalis, submentalis muscle, and/or masseter regions
- Rhythm electrocardiogram (ECG) with 2 or 3 chest leads
- Nasal and/or oral airflow
- Ventilation and respiratory effort by chest-wall and abdominal movement are measured using strain gauges, piezoelectric belts, inductive plethysmography, impedance or inductance pneumography, endo esophageal pressure, or by intercostal EMG
- Gas exchange (oxygen saturation [SpO2]) by oximetry, transcutaneous monitoring, or end-tidal gas analysis
- Extremity muscle activity, motor activity-movement using EMG
- Body positions via mercury switches or by direct observation
- Recordings of vibration (frequency and/or volume) may be recorded
- Transcutaneous CO_2, esophageal pH, penile tumescence, and bipolar EEG
- For polysomnogram, sleep is recorded and staged

[B]**Obstructive sleep apnea signs and symptoms demonstrated by either of the following:**

1. Excessive daytime sleepiness (e.g., falling asleep while driving) and two or more of the following symptoms/conditions:

- Snoring loudly (e.g., enough to be heard through a closed door, waking others)
- Observed sleep apnea, gasping, choking, or breathing that has stopped
- Diagnosed hypertension
- Body mass index (BMI) greater than or equal to 35 kg/m2
- Age 50 years or older
- Large neck circumference (greater than 17 inches in men; greater than 16 inches in women)[17]

2. A validated questionnaire (e.g., STOP BANG or Berlin) indicating at least low risk for OSA may be utilized instead of the above signs and symptoms.[27-28]

Level of Care Criteria
Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
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)
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
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; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

Disclaimer: S Codes are non-covered per CMS guidelines due to their experimental or investigational nature.

Evaluation of Clinical Harms and Benefits

Cohere Health uses the criteria below to ensure consistency in reviewing the conditions to be met for coverage of sleep study or polysomnography. This process helps prevent incorrect denials and inappropriate approvals of medically necessary services. Specifically, limiting incorrect approvals reduces the risks associated with unnecessary procedures, such as complications from surgery, infections, and prolonged recovery times.

The potential clinical harms of using these criteria may include:

- Generally, no major risks or clinical harms are associated with sleep study/ polysomnography, which is non-invasive and painless.
- The most common side effect is skin irritation caused by the adhesive used to attach test sensors to the skin.
- Some patients may find it uncomfortable or difficult to sleep in the laboratory setting with sensors attached to the skin.
- Some patients (e.g., trauma survivors, or those hypersensitive to sound) may experience anxiety due to the unfamiliar settings of the sleep lab and the noise from the recording medical instruments.
- Although most sleep studies are performed at night, night-shift workers who generally sleep during the daytime might find it difficult to sleep at night. This problem can be circumvented by adjusting the time of the procedure based on individualized sleep schedules.
- Increased healthcare costs and complications from the inappropriate use of emergency services and additional treatments.

The clinical benefits of using these criteria include:

- A comprehensive sleep study may help diagnose various sleep disorders (e.g., sleep-related breathing disorders, periodic limb movement disorders, narcolepsy, sleepwalking, insomnia, etc.), including potentially life-threatening conditions such as obstructive sleep apnea (OSA), or adjust treatment plans for known sleep disorders.[29-30]
- Enhanced overall patient satisfaction and healthcare experience.

This policy includes provisions for expedited reviews and flexibility in urgent cases to mitigate risks of delayed access. Evidence-based criteria are employed to prevent inappropriate denials and ensure that patients receive

medically necessary care. The criteria aim to balance the need for effective treatment with minimizing potential harms, providing numerous clinical benefits, and helping avoid unnecessary complications from inappropriate care. In addition, using these criteria is likely to create a consistent set of review criteria, thereby supporting optimal patient outcomes and efficient healthcare utilization.

Medical Evidence

Queisi et al. (2024) performed a retrospective review to compare polysomnographic (PSG) sleep parameters for people with multiple sclerosis (PwMS). The study evaluates a large single cohort from a single center versus existing published standards. A total of 299 PwMS were evaluated at a facility for polysomnography (PSG). Data included total sleep time (TST), sleep efficiency (SE), sleep onset latency (SOL), relative REM latency, total apnea-hypopnea indices (AHI), spontaneous arousal indices (AI), total periodic leg movements indices (PLMI), and sleep architecture metrics (e.g., the percentage spent in stages N1/N2, N3, and REM). Compared to normative data, PwMS had an average of 85.9 minutes shorter TST, 27.3 minutes longer SOL, 62.1 minutes longer REM latency, 10.7% lower SE, 16.4% more N1/N2, and 11.4% less N3. The population demonstrated a high prevalence of obstructive sleep apnea (OSA; 60.7%); the mean AHI was also higher by 11.1 events per hour. Fatigue is a primary symptom among PwMS. The study highlighted the need for established parameters for PwMS.[31]

The American Heart Association (AHA) (2021) issued a scientific statement regarding obstructive sleep apnea (OSA) and cardiovascular disease. Testing is recommended for cardiovascular conditions, including resistant hypertension, pulmonary hypertension, recurrent atrial fibrillation, heart failure, stroke, and for survivors of sudden cardiac death. Follow-up testing is recommended to determine the effectiveness of treatment.[29]

The American Academy of Sleep Medicine (AASM) has published a guideline and position statements related to testing for OSA and other sleep disorders, including the following:

- Das et al. (2022) developed a position statement for AASM focusing on enhancing public health and safety by diagnosing and treating OSA in those in the transportation industry. Recommendations have included mandatory testing and treatment for OSA for rail and highway personnel in safety-sensitive positions.[32]
- Kapur et al. (2017) published the *Clinical Practice Guideline for Diagnostic Testing for Adult Sleep Apnea*, with clinical recommendations using the Grading of Recommendations Assessment, Development, and Evaluation

(GRADE) system. A strong recommendation was made for facility-based testing rather than home testing for patients with significant cardiorespiratory disease, neuromuscular conditions with respiratory muscle weakness, a history of stroke, severe insomnia, or chronic opioid use.[17]

- Kirk et al. (2017) published a position statement regarding home sleep apnea testing for diagnosing OSA in children. The authors concluded that home testing is not recommended in children less than 18 years of age. Limited evidence exists comparing attended PSG to home testing.[16]

Khan et al. (2015) systematically reviewed the peer-reviewed literature regarding central disorders of hypersomnolence. They state that there have been significant advances in recent years, particularly in the diagnosis and management of narcolepsy type 1. A 24-hour PSG is important in the diagnosis of central disorders of hypersomnia.[30]

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Policy Revision History/Information

Original Date: February 6, 2025		
Review History		

Version 2	03/13/2025	• Added criteria from CMS LCD L36593 for sleep study/PSG.
		• Updated the home-based, non-attended sleep study indication with STOP-BANG criteria. An indication was also added - "test is required within 24 months of the first consultation for hypoglossal nerve stimulation (HGNS) implant" (Corral et al, 2017 and Masa et al, 2011).
		• For the suspicion indications and use of Multiple Sleep Latency Testing (MSLT), added "central disorders of hypersomnia with **ANY** of the following:
		  ○ Sleep inertia; **OR**
		  ○ Unrefreshed sleep with adequate or long sleep time; **OR"**
		• Separated the indications for MSLT performed in a sleep laboratory and Maintenance of wakefulness tests (MWT).
		• Added indication for full-night titration study.
		• Rewrote the indication for the split-night protocol for strong pre-test suspicion of OSA.
		• Per CMS, included requirements for place of service and accreditation of the provider.

Version 3	04/17/2025	Boolean logic updates made: ● On p. 6, previously, the first diamond bullet was “ANY of the following” - deleted and moved the bullets over one level to the left. ● On p. 7 - bullet for “Transcutaneous CO2, esophageal pH, penile tumescence, and bipolar EEG” *(changed from an AND to an OR)* ● On p. 7 - the main bullet for “home-based testing” was changed from an ANY to an ALL ● On p. 8, under the bullet for “The patient is an adult with a high pretest probability of moderate to severe obstructive sleep apnea (OSA) with ALL of the following” - indented 2 bullets (“sleep study is recorded” and “sleep study is staged”) to the right to fix logic. ● On p. 15, the indication for “split-night protocol” was updated from ALL to ANY (previously, the patient was required to meet both the initial and repeat criteria together). ● On p. 20, changed the OR to AND - see the indication for “Maintenance of Wakefulness Tests (MWT)”, under the first sub-bullet for initial MWT (“to assess an individual’s ability to remain awake when his or her inability to remain awake constitutes a public or personal safety issue”).
Version 3.1	04/21/2025	Updated policy per CMS revisions for 03/20/2025 Updated Effective Date Updated Links and Bookmarks

Version 4	10/23/2025	Removed L34040 and A57698 links and references from policy- CMS retired 09/11/2025 Added L33405, A57496, L35050, A56923, L36839, A56903, L36861, A56797 to reflect CMS guidelines. Removed specific OSA symptom requirements. Home sleep testing indications refined to align more closely with CMS criteria.