Priority Health	BILLING POLICY No. 118
POLYSOMNOGRAPHY & SLEEP STUDIES	
Date of origin: July 11, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Polysomnography and sleep studies are diagnostic tests utilized to diagnosis sleep disorders such as sleep apnea, narcolepsy, hypersomnia (this is not an all-inclusive list). This testing also provide treatment responses associated with member's care.

Polysomnography can provide distinct observations from a standard sleep test due to the sleep staging observations included in testing outcomes.

MEDICAL POLICY

- Sleep Apnea: Obstructive and Central (#91333)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Billing details

One testing session associated with a polysomnography and electroencephalogram session are payable as this is the standard to diagnosis sleep apnea.

We will not reimburse more than two polysomnography sessions for diagnosing of sleep disorders or modifications to a treatment plan during a 12-month period.

Utilizing polysomnography to titrate CPAP therapy is payable for a single session. Routinely utilizing polysomnography to titrate CPAP is not separately payable.

We will reimburse up to 3 sleep nap sessions when diagnosing narcolepsy as this is the standard utilized to confirm this diagnosis.

Multiple sleep latency studies inherently include multiple sessions and should only be coded with 1 unit.

Home sleep studies
One home sleep study is payable per 12-month period. Any additional sessions would require supporting documentation detailing medical necessity.

At home sleep apnea devices, such as watchpat, should be coded with CPT 95800 or 95801.

Modifier 52 should be coded with the following sleep studies when time parameters are not met.

- Sleep studies coded with CPT 95800, 95801, 95806, 95807, 95810, 95811 that require less than 6 hours
- Sleep studies coded with CPT 95782 and 95782 that requires less than 7 hours
- Studies with less than four nap opportunities for CPT 95805

This would include sleep studies that are terminated due to patient safety reasons. Reduction in reimbursement is applied.

All sleep services (95800-95811) include recording, interpretation and report.

CPT 95803

Coding specifics

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

Other policies and guidelines may apply.

- 95782
- 95783
- 95800
- 95801
- 95803
- 95805
- 95806
- 95807
- 95808
- 95810
- 95811

Home sleep study

- G0398
- G0399
- G0400

Modifiers

Modifier 52 – Reduced services

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

Place of service
Sleep studies must be performed by a certified sleep lab facility and interpretations performed by a certified sleep specialist.

Home-based studies would be billed with appropriate home place of service (12).

Although member may have an overnight stay, this does not designate member as inpatient status. This overnight stay would not be separately reimbursed as this is considered as a component of the sleep study testing.

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

REFERENCES

- Medicare Benefit Policy Manual (CMS)
- Billing and Coding: Polysomnography and Other Sleep Studies (A56903) (CMS)

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made