

POLYSOMNOGRAPHY & SLEEP STUDIES

Date of origin: July 11, 2025

Review dates: 08/2025

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 95783 that require 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.

CPT codes 95810 and 95811:

These codes relate to polysomnography (sleep studies). CPT code 95810 is typically used for diagnostic sleep studies, while 95811 is for split-night studies or CPAP titration studies

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

The reimbursement policy will not allow CPT codes 95810 and 95811 to be billed separately for the same night. Providers should ensure that they are billed appropriately based on the services performed and in accordance with the guidelines set forth by the AMA, NCCI, and CMS.

Repeat testing and CPT code 95803

CPT code 95803 represents actigraphy testing, including recording, analysis, interpretation, and report. It involves the use of a device worn on the wrist to track sleep and movement patterns over a period of 3 to 14 days.

Repeat Testing: Medically necessary for individuals with persistent or new symptoms despite appropriate treatment.

- Do not report 95803 more than once in any 14-day period.
- Do not report 95803 in conjunction with 95806-95811

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 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, HCPCS, 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
Aug 2025	Adding 95810 and 95811 to be billed separately for the same night Do not report 95803 more than once in any 14 day period. Do not report 95803 in conjunction with 95806-95811