Diagnosis and Treatment of Obstructive Sleep Apnea for Adults

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Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary diagnosis and treatment of obstructive sleep apnea for adults.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children (DHCP) and Diamond State Health Plan Plus members.

PROCEDURES

A prior authorization is required.

Obstructive sleep apnea (OSA) diagnosis is based upon the presence or absence of related symptoms, as well as the frequency of respiratory events during sleep (e.g., apneas, hypopneas, and respiratory effort related arousals [RERAs]) as measured by polysomnography (PSG) either in a clinic/facility or at home.

OSA is characterized by:

- Fifteen or more predominantly obstructive respiratory events (apneas, hypopneas, or RERAs) per hour of sleep (for PSG) or recording time (for at home PSG), regardless of the presence of associated symptoms or comorbidities; or
- Five or more predominantly obstructive respiratory events (obstructive and mixed apneas, hypopneas, or RERAs) per hour of sleep (for PSG) or recording time (for at home PSG) in an individual and at least ONE of the following:
    - Habitual snoring, or breathing interruptions; or
    - Hypertension, mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation, or Type II Diabetes Mellitus (DM); or
    - Sleepiness, non-restorative sleep, fatigue, or insomnia symptoms; or
    - Morning headache; or
    - Waking up with breath holding, gasping, or choking.

OSA severity classification is based on two measures:

- Apnea/hypopnea index (AHI) which includes the total number of apneas and hypopneas recorded during sleep, divided by the hours of sleep recorded; or
- Respiratory disturbance index (RDI) which includes the total number of apneas, hypopneas, and RERA during sleep, divided by the hours of sleep observed.
- Severity classification:
- Mild OSA: RDI or AHI five to 14 respiratory events per hour of sleep.
- Moderate OSA: RDI or AHI 15 to 30 respiratory events per hour of sleep.
- Severe OSA: RDI or AHI greater than 30 respiratory events per hour of sleep.

UNATTENDED/UNSUPERVISED PSG DIAGNOSTIC TESTING

A single unattended/unsupervised PSG test with a minimum of four recording channels including oxygen saturation, respiratory movement, airflow, and EKG or heartrate or peripheral arterial tone (PAT), oximetry, heart rate and actigraphy may be considered medically necessary for ANY of the following conditions:

- Adult individuals who are at high risk for OSA and have no current evidence of a health condition that may alter ventilation; or
- A screening such as Stop/Bang tool for adult individuals who are scheduled for bariatric surgery and have no evidence of a health condition that might alter ventilation or require alternative treatment; or
    - **NOTE**: Stop/Bang includes:
        - Male individual greater than 60 years of age; or
        - Individual has a thick neck as follows:
            - Greater than 17 inches in men; or
            - Greater than 16 inches in women; or
            - Individual has craniofacial or upper airway anomalies such as abnormal or short maxillary or short mandibular size; or
            - Individual has a wide craniofacial base; or
            - Individual has tonsillar/adenoid hypertrophy; or
- Adult individuals requiring positive airway pressure (PAP) via continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP) initiation or titration with sleep related breathing disorders with EITHER of the following proven options for titration:
    - Auto-titrating continuous positive airway pressure (APAP) devices when used in the self-adjusting mode for unattended treatment; or
    - In an unattended way to determine a fixed CPAP treatment pressure for individuals with moderate to severe OSA without significant comorbidities; or
- Adult individuals to monitor the response to non-CPAP treatments for OSA, including but not limited to:
    - Evaluating response to oral appliance treatment; or
    - Evaluating for surgical treatment/upper airway surgery; or

- Evaluation after significant weight loss of greater than 10 percent.

Unattended/unsupervised PSGs performed in the individual's home must be interpreted by a qualified physician or an active staff member of a sleep center or laboratory accredited by the AASM or The Joint Commission.

Unattended/unsupervised home PSG not meeting the criteria as indicated in this policy is considered not medically necessary.

REPEAT UNATTENDED/UNSUPERVISED HOME PSG

Repeat unattended/unsupervised sleep studies for adults may be considered medically necessary with a minimum of three sensors as described above in EITHER of the following circumstances:

- To assess efficacy of surgery or oral appliances/devices; or
- To re-evaluate the diagnosis of OSA and need for continued CPAP (e.g., if there is a significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued).

Multiple consecutive nights of attended or unattended sleep studies that do not meet the above criteria for repeat studies are considered not medically necessary.

FACILITY/LABORATORY ATTENDED PSG

Supervised PSG with a minimum of seven recording channels (including electroencephalography (EEG), electrooculogram (EOG), chin electromyography (EMG), electrocardiogram (ECG) or heart rate, airflow, respiratory effort, and oxygen saturation) performed in a sleep facility/laboratory may be considered medically necessary in individuals with a moderate or high pretest probability of OSA for the following indications:

- Individual does not meet criteria for an unattended home sleep apnea test as outlined in this policy; or
- A previous home study failed to establish the diagnosis of OSA in an individual with a high pretest probability of OSA; or
- A previous home study was technically inadequate; or
- Failure of resolution of symptoms or recurrence of symptoms during treatment; or
- Observed apneas during sleep and AT LEAST two of the following:
  - Craniofacial or upper airway soft tissue abnormalities, including adenotonsillar hypertrophy; or
  - Excessive daytime sleepiness evidenced by:
    - Epworth Sleepiness Scale greater than 10; or
    - Inappropriate daytime napping; or
    - Sleepiness that interferes with daily activities and is not explained by other conditions; or
  - Gasping/Choking episodes with awakenings; or
  - Habitual snoring; or
  - Individual screening for bariatric surgery; or

NOTE: If no bed partner is available to report snoring or observed apneas, other signs, and symptoms suggestive of OSA may be considered as outlined below:

- Male individual greater than 60 years of age; or
- Individual has a thick neck as follows:
  - Greater than 17 inches in men; or
  - Greater than 16 inches in women; or
- Individual has craniofacial or upper airway anomalies such as abnormal or short maxillary or short mandibular size; or
- Individual has a wide craniofacial base; or
- Individual has tonsillar/adenoid hypertrophy.

AND

- The presence of ONE of the following comorbidities (disease process or sleep disorder) that might alter ventilation or decrease the accuracy of a home sleep apnea test, which may include, but not limited to:
    - Atrial fibrillation; or
    - Central sleep apnea; or
    - Cerebrovascular Attack/Accident (CVA) (stroke or transient ischemic attack [TIA]); or
    - Chronic opioid use; or
    - Circadian rhythm disorder; or
    - Coronary Artery Disease (CAD); or
    - Type II DM; Type II or
    - Heart Failure (HF); or
    - Hypertension; or
    - Insomnia; or
    - Parasomnias; or
    - Narcolepsy; or
    - Neuromuscular disease; or
    - Obesity; or
    - Obesity hypoventilation syndrome; or
    - Periodic limb movement in sleep; or
    - Pulmonary disease, chronic; or
    - Restless Leg Syndrome; or
    - Significant tachycardia; or
- In individuals with sleep related breathing disorders requiring PAP via CPAP or BiPAP initiation and titration with the following options:
    - Assessment of treatment results to evaluate response to oral appliance treatment; or
    - Surgical treatment for OSA; or
    - Resolution of OSA after significant weight loss of greater than 10 percent.
- A facility/attended PSG may be considered medically necessary for the following non-OSA indications:
    - Potentially injurious parasomnia; or
    - Neuromuscular diseases such as:
        - ALS; or
        - Myotonic dystrophy; or
        - Parkinson's disease; or
        - Central sleep apnea; or
        - Suspected narcolepsy.

REPEAT FACILITY/LABORATORY ATTENDED SLEEP STUDIES

A repeat supervised polysomnography performed in a sleep laboratory may be considered medically necessary for ANY of the following circumstances:

- To initiate and titrate continuous positive airway pressure (CPAP) in adult individuals with clinically significant OSA defined as those individuals who have (see next policy section below):
    - An AHI of at least 15 per hour; or
    - An AHI of at least five per hour in an individual with excessive daytime sleepiness or hypertension; or
- Failure of resolution of symptoms or recurrence of symptoms during treatment; or
- To assess efficacy of surgery or oral appliances/devices; or
- To re-evaluate the diagnosis of OSA and need for continued CPAP, e.g., if there is a significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued.

Polysomnography or repeat polysomnography sleep studies that do not meet the above criteria for repeat studies are considered not medically necessary.

POLYSOMNOGRAPHY/PERIODIC LIMB MOVEMENT DISORDER

PSG may be considered medically necessary for the diagnosis of periodic limb movement disorder when ALL of the following are criteria met:

- A complaint of repetitive limb movement during sleep by the individual or an observer; and
- No other concurrent sleep disorder; and
- At least ONE of the following is present:
    - Frequent awakenings; or
    - Fragmented sleep; or
    - Difficulty maintaining sleep; or
    - Excessive daytime sleepiness.

PAG not meeting the criteria as indicated in the policy are considered not medically necessary.

CPAP OR BIPAP INITIATION AND TITRATION RELATED TO PSG

For CPAP initiation and titration, a split-night study (initial PSG followed by CPAP titration during PSG on the same night) is an alternative to one full night of PSG followed by a second night of titration when ALL three of the following criteria are met:

- An AHI of at least 40 events per hour of sleep is documented during a minimum of two hours of sleep. Alternatively, an AHI of 20 to 39 events per hour of sleep is documented during a minimum of two hours of sleep and there is strong supportive evidence of OSA (e.g., repetitive long obstructions with major desaturations); and
- Positive airway pressure titration is conducted for more than three hours, since obstructive events can worsen as the night progresses; and
- Elimination or near elimination of obstructive events with positive airway pressure is documented by PSG during rapid eye movement (REM) and non-REM (NREM) sleep. This should include REM sleep in the supine position when apneas are most likely to occur.

NOTE: A second full night PSG should be performed for titration of positive airway pressure if the second and third criteria listed above are not met.

Notes:

- A split-night study, in which severe OSA is documented during the first portion of the study using polysomnography, followed by CPAP during the second portion of the study, can eliminate the need for a second study to titrate CPAP.
- Respiratory disturbance index may be used in place of an AHI in unattended sleep studies.

The use of an abbreviated cardiorespiratory daytime sleep study (PAP-NAP) as a supplement to standard sleep studies or to acclimatize an individual to PAP not meeting the criteria as indicated in this policy is considered experimental/investigational and therefore, non-covered because the safety and/or effectiveness of this service cannot be established by the available published peer-reviewed literature.

MULTIPLE SLEEP LATENCY TEST (MSLT)/MAINTENANCE OF WAKEFULNESS TEST (MWT)

MSLT/MWT in the diagnosis of OSA is considered not medically necessary EXCEPT to exclude or confirm narcolepsy or idiopathic hypersomnia.

MSLT/MWT not meeting the criteria as indicated in this policy is considered not medically necessary.

ACTIGRAPHY

Actigraphy may be considered medically necessary when used as a component of PSG in order to evaluate sleep disorders. When used as a component of PSG actigraphy should not be reported separately.

Actigraphy used as a sole technique to record and analyze body movement to evaluate sleep disorders not meeting the criteria as indicated in this policy is considered not medically necessary.

HYPOGLOSSAL NERVE STIMULATORS

Hypoglossal nerve stimulators may be considered medically necessary in adults with OSA when ALL the following criteria are met:

- Age greater than or equal to 18 years; and
- AHI greater than or equal to 15 with less than 25 percent central apneas; and
- CPAP failure (residual AHI greater than 20 or failure to use CPAP greater than or equal to four (4) hours per night for five or more nights per week) or inability to tolerate CPAP; and
- Body mass index less than or equal to 32 kg/m2; and
- Nonconcentric retropalatal obstruction on Drug-Induced Sleep Endoscopy (DISE).

Hypoglossal nerve stimulators may be considered medically necessary in young adults with Down syndrome and OSA under ALL the following conditions:

- Age 18 to 21 years; and
- AHI greater than 10 and less than 50 with less than 25 percent central apneas after prior adenotonsillectomy; and
- Have either tracheotomy or be ineffectively treated with CPAP due to noncompliance, discomfort, un-desirable side effects, persistent symptoms despite compliance use, or refusal to use the device; and
- Body mass index less than or equal to the 95th percentile for age; and
- Non-concentric retropalatal obstruction on DISE.

Use of hypoglossal nerve stimulators for OSA that does not meet the criteria as indicated in this policy is considered not medically necessary.

SURGICAL TREATMENT

The following surgical interventions may be considered medically necessary for the treatment of clinically significant OSA in adults who have failed an adequate trial of CPAP or failed an adequate trial of an oral appliance:

- Adenoidectomy; or
- Adenotonsillectomy; or
- Hyoid suspension; or
- Maxillofacial surgery, including mandibular-maxillary advancement (MMA); or
- Palatopharyngoplasty, including but not limited to:
- Expansion sphincter pharyngoplasty; or
- Lateral pharyngoplasty; or
- Palatal advancement pharyngoplasty; or
- Relocation pharyngoplasty; or
- Uvulopalatal flap; or

- Tongue modification, surgical; or
- Tonsillectomy; or
- Tracheostomy.

Surgical treatment of OSA not meeting the criteria as indicated in this policy is considered not medically necessary.

EXPERIMENTAL/INVESTIGATIONAL PROCEDURES

The following minimally invasive surgical procedures for the treatment of OSA are considered experimental/investigational and, therefore, non-covered because the safety and effectiveness of these services cannot be established by the available published peer-reviewed literature:

- Atrial overdrive pacing; or
- Laser-assisted palatoplasty (LAUP) or radiofrequency volumetric tissue reduction of the palatal tissues; or
- Laser-assisted tonsillectomy or laser ablation of the tonsils (LAT); or
- Palatal stiffening procedures including, but not limited to, cautery-assisted palatal stiffening operation, injection of a sclerosing agent (CAPSO), and the implantation of palatal implants; or
- Partial glossectomies; or
- Polypectomy; or
- Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues (e.g., Somnoplasty); or
- Septoplasty; or
- Tongue base suspension (e.g., Repose™ System); or
- Turbinectomy; or
- Uvulectomy; or
- All other minimally invasive surgical procedures not described above.

ADDITIONAL INFORMATION

Epworth Sleepiness Scale		
Situation	Situation Responses	Situation Response Score
Sitting and reading	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Watching television	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	

Sitting inactive in a public place, for example, a theater or a meeting	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
As a passenger in a car for a hour without a break	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Lying down to rest in the afternoon	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting and talking to someone	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
In a car while stopped in traffic	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	

A score of 10 or greater indicates a possible sleep disorder.

POST-PAYMENT AUDIT STATEMENT

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

PLACE OF SERVICE: INPATIENT/OUTPATIENT

CODING REQUIREMENTS

CPT code	Description
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 rates, oxygen saturation, respiratory airflow, and respiratory effort (e.g., 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 bilevel ventilation, attended by a technologist.
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array.
64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator.
64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array.
21122	Genioplasty; sliding osteotomies, two or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin.
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts).
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation.
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation.
21199	Osteotomy, mandible, segmental; with genioglossus advancement.
21685	Hyoid myotomy and suspension.
30130	Excision inferior turbinate, partial or complete, any method.
30140	Submucous resection inferior turbinate, partial or complete, any method.
30520	Septoplasty or submucous resection, with or without cartilage scoring contouring or replacement with graft.
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy, or debridement (separate procedure).
31600	Tracheostomy, planned (separate procedure).
41120	Glossectomy; less than one-half tongue.
41130	Glossectomy; hemiglossectomy.
41512	Tongue base suspension, permanent suture technique.
41530	Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session.
42140	Uvulectomy, excision of uvula.
42145	Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty).

42821	Tonsillectomy and adenoidectomy; age 12 or over.
42826	Tonsillectomy, primary of secondary; age 12 or over.
42831	Adenoidectomy, primary; age 12 or over.
42835	Adenoidectomy, secondary; younger than age 12.
42836	Adenoidectomy, secondary; age 12 or over.

DIAGNOSIS CODES

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES 95805

Codes						
G47.411	G47.419	G47.421	G47.429			

COVERED DIAGNOSIS CODES FOR PROCEDURE CODES 64582, 64583, 64584

Codes						
G47.33	Q90.0	Q90.1	Q90.2	Q90.9		

NONCOVERED DIAGNOSIS CODES FOR PROCEDURE CODES 30130, 30140, 30520, 31237, 41120, 41130, 41512, AND 42140

Codes						
G47.33						

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Health Options contract.

PROFESSIONAL STATEMENTS AND SOCIETAL POSITIONS GUIDELINES

American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) 2016

The American Academy of Otolaryngology-Head and Neck Surgery considers upper airway stimulation (UAS) via the hypoglossal nerve for the treatment of adult obstructive sleep apnea syndrome to be an effective second-line treatment of moderate to severe obstructive sleep apnea in individuals who are intolerant or unable to achieve benefit with positive pressure therapy (PAP). Not all adult individuals are candidates for UAS therapy and appropriate polysomnographic, age, BMI and objective upper airway evaluation measures are required for proper individuals' selection.

American Academy of Sleep Medicine (AASM) Oral Appliance Therapy – 2015

The AASM along with the American Academy of Dental Sleep Medicine (AADSM) engaged a seven-member task force for the treatment of OSA and snoring with oral appliance therapy developed recommendations and assigned strengths based on the quality of the evidence counterbalanced by an assessment of the relative benefit of the treatment versus the potential harms. The AASM and AADSM Board of Directors approved the final guideline recommendations.

Recommendations:

- That sleep physicians prescribe oral appliances, rather than no therapy, for adult individuals who request treatment of primary snoring (without obstructive sleep apnea).
- When oral appliance therapy is prescribed by a sleep physician for an adult individual with obstructive sleep apnea, we suggest that a qualified dentist use a custom, titratable appliance over non-custom oral devices.
- Sleep physicians consider prescription of oral appliances, rather than no treatment, for adult individuals with obstructive sleep apnea who are intolerant of CPAP therapy or prefer alternate therapy.
- Qualified dentists provide oversight— rather than no follow-up—of oral appliance therapy in adult individuals with obstructive sleep apnea, to survey for dental-related side effects or occlusal changes and reduce their incidence.
- Sleep physicians conduct follow-up sleep testing to improve or confirm treatment efficacy, rather than conduct follow-up without sleep testing, for individuals fitted with oral appliances.
- Sleep physicians and qualified dentists instruct adult individuals treated with oral appliances for obstructive sleep apnea to return for periodic office visits— as opposed to no follow-up—with a qualified dentist and a sleep physician.

Diagnosing OSA in Adults – 2017

AASMs recommendations are intended as a guide for clinicians diagnosing OSA in adults. The ultimate judgment regarding propriety of any specific care must be made by the clinician in light of the individual circumstances presented by the individual, available diagnostic tools, accessible treatment options, and resources:

Good Practice Statements regarding diagnostic testing:

Diagnostic testing for OSA should be performed in conjunction with a comprehensive sleep evaluation and adequate follow-up. Polysomnography is the standard diagnostic test for the diagnosis of OSA in adult individuals in whom there is a concern for OSA based on a comprehensive sleep evaluation:

- Clinical tools, questionnaires and prediction algorithms are not used to diagnose OSA in adults, in the absence of polysomnography or home sleep apnea testing.
- Polysomnography, or home sleep apnea testing with a technically adequate device, be used for the diagnosis of OSA in uncomplicated adult individuals presenting with signs and symptoms that indicate an increased risk of moderate to severe OSA.
- If a single home sleep apnea test is negative, inconclusive, or technically inadequate, polysomnography be performed for the diagnosis of OSA.
- Polysomnography, rather than home sleep apnea testing, be used for the diagnosis of OSA in individuals with significant cardiorespiratory disease, potential respiratory muscle weakness due to neuromuscular condition, awake hypoventilation or suspicion of sleep related hypoventilation, chronic opioid medication use, history of stroke or severe insomnia.
- If clinically appropriate, a split-night diagnostic protocol, rather than a full-night diagnostic protocol for polysomnography be used for the diagnosis of OSA.
- When the initial polysomnogram is negative and clinical suspicion for OSA remains, a second polysomnogram be considered for the diagnosis of OSA.

Clinical Use of a Home Sleep Apnea Test – 2017

American Academy of Sleep Medicine (AASM):

- Only a physician can diagnose medical conditions such as OSA and primary snoring. Throughout this statement, the term “physician” refers to a medical provider who is licensed to practice medicine. A home

sleep apnea test (HSAT) is an alternative to polysomnography for the diagnosis of OSA in uncomplicated adults presenting with signs and symptoms that indicate an increased risk of moderate to severe OSA.
- The need for, and appropriateness of, an HSAT must be based on the individual's medical history and a face-to-face examination by a physician, either in person or via telemedicine;
- An HSAT is a medical assessment that must be ordered by a physician to diagnose OSA or evaluate treatment efficacy;
- An HSAT should not be used for general screening of asymptomatic populations; diagnosis, assessment of treatment efficacy, and treatment decisions must not be based solely on automatically scored HSAT data, which could lead to sub-optimal care that jeopardizes individual health and safety;
- The raw data from the HSAT device must be reviewed and interpreted by a physician who is either board-certified in sleep medicine or overseen by a board-certified sleep medicine physician.

Use of Actigraphy in Adult and Pediatric [Individuals] – 2018

AASM recommendations are intended as a guide for clinicians using actigraphy in evaluating individuals with sleep disorders and circadian rhythm sleep-wake disorders, and only apply to the use of FDA-approved devices.

Each recommendation statement is assigned a strength (“Strong” or “Conditional”). A “Strong” recommendation (i.e., “We recommend…”) is one that clinicians should follow under most circumstances. A “Conditional” recommendation (i.e., “We suggest…”) reflects a lower degree of certainty regarding the outcome and appropriateness of the individual-care strategy for all individuals. The ultimate judgment regarding any specific care must be made by the treating clinician and the individual, taking into consideration the individual circumstances of the individual, available treatment options, and resources.

- Suggest clinicians use actigraphy to estimate sleep parameters in adult individuals with insomnia disorder.
- Suggest clinicians use actigraphy in the assessment of pediatric individuals with insomnia disorder.
- Suggest clinicians use actigraphy in the assessment of adult individuals with circadian rhythm sleep-wake disorder.
- Suggest that clinicians use actigraphy in the assessment of pediatric individuals with circadian rhythm sleep-wake disorder.
- Suggest clinicians use actigraphy integrated with home sleep apnea test devices to estimate total sleep time during recording (in the absence of alternative objective measurements of total sleep time) in adult individuals suspected of sleep-disordered breathing.
- Suggest clinicians use actigraphy to monitor total sleep time prior to testing with the Multiple Sleep Latency Test in adult and pediatric individuals with suspected central disorders of hypersomnolence.
- Suggest clinicians use actigraphy to estimate total sleep time in adult individuals with suspected insufficient sleep syndrome.
- Recommend clinicians not use actigraphy in place of electromyography for the diagnosis of periodic limb movement disorder in adult and pediatric individuals.

Treatment of OSA with PAP Therapy – 2019

Based on expert consensus from the AASM, the following good practice statements and their implementation is necessary for appropriate and effective management of individuals with OSA treated with positive airway pressure:

- Treatment of OSA with PAP therapy should be based on a diagnosis of OSA established using objective sleep apnea testing.
- Adequate follow-up, including troubleshooting and monitoring of objective efficacy and usage data to ensure adequate treatment and adherence, should occur following PAP therapy initiation and during treatment of OSA.

The following recommendations are intended as a guide for clinicians using PAP to treat OSA in adults. A STRONG (i.e., “We recommend…”) recommendation is one that clinicians should follow under most circumstances. A CONDITIONAL recommendation (i.e., “We suggest…”) reflects a lower degree of certainty regarding the outcome and appropriateness of the individual-care strategy for all individuals. The ultimate judgment regarding any specific care must be made by the treating clinician and the individual, taking into consideration the individual circumstances of the individuals, available treatment options, and resources.

- We recommend that clinicians use PAP, compared to no therapy, to treat OSA in adults with excessive sleepiness.
- We suggest that clinicians use PAP, compared to no therapy, to treat OSA in adults with impaired sleep-related quality of life.
- We suggest that clinicians use PAP, compared to no therapy, to treat OSA in adults with comorbid hypertension.
- We recommend that PAP therapy be initiated using either APAP at home or in-laboratory PAP titration in adults with OSA and no significant comorbidities.
- We recommend that clinicians use either CPAP or APAP for ongoing treatment of OSA in adults.
- We suggest that clinicians use CPAP or APAP over BPAP in the routine treatment of OSA in adults.
- We recommend that educational interventions be given with initiation of PAP therapy in adults with OSA.
- We suggest that behavioral and/or troubleshooting interventions be given during the initial period of PAP therapy in adults with OSA.
- We suggest that clinicians use telemonitoring-guided interventions during the initial period of PAP therapy in adults with OSA.

Reference

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POLICY UPDATE HISTORY

09/20/2021	Approved in Medical Policy Committee
11/30/2022	Annual review; approved in Medical Policy Committee
12/2022	Approved in QI/UM
03/22/2023	Annual review; approved in Medical Policy Committee
03/28/2023	Approved in QI/UM