

	<p>Sleep Studies in Children</p>	
<p>Guideline # 6235</p>	<p>Categories Clinical → Care Management CM</p>	<p>This Guideline Applies To: Texas Children's Health Plan</p>
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GUIDELINE

1. All requests for prior authorization for sleep studies in children are received via fax, phone or mail by the Utilization Management Department and processed during normal business hours.
2. The Utilization Management professional receiving the request evaluates the submitted information to determine if the documentation supports the sleep study as an eligible service.
3. To request prior authorization for a sleep study, the facility providing the services must be accredited by the AASM or the Joint Commission of Accreditation of Healthcare Organizations. The physician providing supervision of the sleep facility and the specialist interpreting the sleep study must be board-certified or board-eligible, as outlined in the AASM guidelines.
4. To request prior authorization for a sleep study, the following documentation must be submitted by the ordering provider:
 - 4.1. Completed Prior Authorization form
 - 4.2. Clinical documentation supporting the medical necessity of the requested study
5. Facility/laboratory (supervised) sleep studies in children (17 years and younger) may be considered **medically necessary** when **any one** of the following are met:
 - 5.1. Clinical assessment suggests the diagnosis of congenital central alveolar hypoventilation syndrome
 - 5.2. Clinical concern of risk for sleep disordered breathing due to severe neuromuscular or genetic disorders (e.g. Down syndrome, Prader-Willi syndrome, mucopolysaccharidosis)

- (Hunter, Hurler, Morquio, and Schie syndromes), Muscular Dystrophies, Spinal Muscular Atrophy, Chiari malformations, myelomeningocele) or severe chest wall deformities (severe scoliosis, severe restrictive lung disease); or
- 5.3. Craniofacial anomalies that obstruct the upper airway (eg, craniofacial anomalies (cleft palate status post repair, Treacher Collins Syndrome, Pierre Robin Sequence), Achondroplasia, severe Laryngomalacia); or
 - 5.4. Clinical concern of risk for sleep disordered breathing and any of the following complaints or associated features of obstructive sleep apnea (OSA):
 - 5.4.1. Obesity
 - 5.4.2. Hypertension; or
 - 5.5. Adenotonsillectomy is being considered for treatment of obstructive sleep apnea (preoperative indication); or
 - 5.6. Suspected narcolepsy or suspected idiopathic hypersomnia when a Multiple Sleep Latency Test (MSLT) is planned and adequate amount of sleep is documented; or
 - 5.7. Children suspected of having periodic limb movement disorder (PLMD); or
 - 5.8. Non-REM (NREM) parasomnias (somnambulism/sleep walking, confusional arousals, sleep terrors) and symptoms of sleep disordered breathing (SDB); or
 - 5.9. Seizures/epilepsy; or
 - 5.10. Positive airway pressure (PAP) titration with a diagnosis of obstructive sleep apnea (OSA); or
 - 5.11. Frequent snoring > 3 nights per week and any of the following complaints or associated features of obstructive sleep apnea (OSA):
 - 5.11.1. Labored breathing during sleep; or
 - 5.11.2. Gasps/snorting noises/observed episodes of apnea; or
 - 5.11.3. Cyanosis; or
 - 5.11.4. Daytime sleepiness (interferes with daily activities and is not explained by other conditions, or patient exhibits behavior that may indicate increased efforts to stay awake such as difficulty in attentiveness, hyperactivity, aggressive or disruptive behavior); or
 - 5.11.5. Headaches on awakening; or
 - 5.11.6. Sleeping in a seated position or with neck hyperextended; or Sleep enuresis after at least six months of continence (secondary enuresis in children > 5 years, which is when nocturnal bladder continence is developmentally expected); or
 - 5.11.7. Attention-deficit/hyperactivity disorder (ADHD); or

- 5.11.8. Learning problems associated to poor school performance due to excessive daytime sleepiness; or
- 5.11.9. Overweight (BMI percentile: > the 95th percentile for age and gender); or
- 5.11.10. Underweight (BMI percentile: less than the 5th percentile for age and gender); or
- 5.11.11. Failure to thrive; or
- 5.11.12. Tonsillar hypertrophy; or
- 5.11.13. Adenoidal Facies (dentofacial growth anomaly caused by long term adenoid hypertrophy); or
- 5.11.14. High arched palate; or
- 5.11.15. Micrognathia (jaw is undersized)/retrognathia (abnormal posterior positioning of the maxilla or mandible); or
- 5.11.16. Hypertension

5.12. **Repeat** supervised facility/laboratory sleep study in children may be considered medically necessary when any one of the following are met:

- 5.12.1. Initial sleep study is inadequate or non-diagnostic and the accompanying caregiver reports that the child's sleep and breathing patterns during the testing were not representative of the child's sleep at home; or
- 5.12.2. A child with previously diagnosed and treated obstructive sleep apnea who continues to exhibit persistent snoring or other symptoms of sleep disordered breathing; or
- 5.12.3. Children on chronic PAP support to evaluate whether pressure requirements have changed as a result of the child's growth and development, progression of the underlying severe chronic progressive disease, or the presence of recurrent symptoms while on PAP support; or
- 5.12.4. If obesity was a major contributing factor and significant weight loss (10% of body weight or greater) has been achieved, repeat testing may be indicated to determine the need for continued therapy; or
- 5.12.5. Six to eight weeks post adenotonsillectomy or other pharyngeal surgery for obstructive sleep apnea (OSA) and obstructive sleep apnea (OSA) was present on pre-operative sleep study or other symptoms related to pre-operative sleep disordered breathing persist or recur.

6. Multiple Sleep Latency Testing (MSLT) may be considered medically

- 6.1. For the evaluation of symptoms of narcolepsy, to confirm the diagnosis; or
- 6.2. Suspected idiopathic hypersomnia; or
- 6.3. When performed for any one of the following:

- 6.3.1. The first test was invalid or uninterpretable; or
- 6.3.2. The response to treatment needs to be determined; or
- 6.3.3. The patient is suspected of having more than one sleep disorder (e.g. diagnosis of obstructive sleep apnea (OSA) and the patient continues to have excessive daytime sleepiness despite treatment); or
- 6.3.4. The most recent prior MSLT was conducted two (2) or more years ago

7. Billing considerations:

- 7.1. All sleep studies are limited to one per day, and two per rolling year by any provider.
- 7.2. Unattended sleep studies (95800, 95801, 95806) are not a benefit.
- 7.3. Pneumocardiograms (procedure code 95807) are limited to clients who are birth through 12 months of age.
- 7.4. The following CPT codes may be used when reporting sleep study services:
 - 7.4.1. 95803 Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)
 - 7.4.2. 95805 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
 - 7.4.3. 95807 (Pneumocardiogram) Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist.
 - 7.4.4. 95808 Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
 - 7.4.5. 95810 Polysomnography Age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
 - 7.4.6. 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
 - 7.4.7. 95782 Polysomnography younger than 6 years, sleep staging 4 or more additional parameters of sleep, attended by technologist
 - 7.4.8. 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 technologist

8. Home sleep studies/unattended sleep studies/ambulatory sleep studies outside the sleep laboratory in children have been used predominately in the research setting. There have been a small amount of research comparing home/unattended sleep studies to traditional in laboratory attended sleep studies, and there is insufficient data upon which to base reliable clinical recommendations for children at this time and therefore this testing is considered **investigational and not a covered benefit**.
9. Requests that do not meet the criteria established by this guideline will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.
10. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

REFERENCES:

Peer Reviewed Publications:

- UpToDateExternal Site. Evaluation of Suspected Obstructive Sleep Apnea in Children, Shalini Paruthi, M.D.. Topic last updated January 3, 2019. ,
- UpToDateExternal Site. Management of Obstructive Sleep Apnea in Children, Shalini Paruthi, M.D.. Topic last updated September 11, 2019,

Government Agency, Medical Society, and Other Publications:

- Texas Medicaid Provider Procedures Manual, section 9.2.68.2 . October 2019.
http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2019/Oct_2019%20TMPPM.pdf. Accessed 10/4/2019
- American College of Obstetricians and Gynecologists (ACOG). ACOG Committee on Practice Bulletins. American Academy of Sleep Medicine (AASM) Practice Parameters for the Respiratory Indications for Polysomnography in Children, Sleep, Vol. 34, No.3, 2011.
- American Academy of Sleep Medicine (AASM) Practice Parameters for the Non-Respiratory Indications for Polysomnography and Multiple Sleep Latency Testing for Children, Sleep, Vol. 35, No.11, 2012
- American Academy of Sleep Medicine (AASM) Clinical Guidelines for the Manual Titration of Positive Airway Pressure in Patients with Obstructive Sleep Apnea, Journal of Clinical Sleep Medicine, Vol. 4, No.2, 2008
- American Thoracic Society External Site, Patient Information Series, Obstructive Sleep Apnea in Children. <https://www.thoracic.org/patients/patient-resources/resources/osa-in-children.pdf>. Accessed 10/4/2019.
- American Academy of Pediatrics, Diagnosis and Management of Childhood Obstructive Sleep Apnea Syndrome External Site. Revised guidelines 2012.
<https://pediatrics.aappublications.org/content/130/3/576>. Accessed 10/4/2019.
- American Sleep Apnea Association External Site, Children’s Sleep Apnea.
<https://www.sleepapnea.org/treat/childrens-sleep-apnea/>. Accessed 10/4/2019.

RELATED DOCUMENTS:

REFERENCES:

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