BOSTON MEDICAL CENTER HEALTHNet PLAN
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WELL SENSE HEALTH PLAN
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Medical Policy

Actigraphy Testing

Policy Number: OCA 3.712
Version Number: 16
Version Effective Date: 12/01/21

Product Applicability	☐ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☐ NH Medicaid	☒ MassHealth ACO
☒ NH Medicare Advantage	☒ MassHealth MCO
	☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers actigraphy testing **experimental and investigational or NOT medically necessary** when used as a **stand-alone method** for the diagnosis, evaluation, and/or management of sleep disorders or for any other indication. It will be determined during the Plan's standard prior authorization review process if the service is considered experimental and investigational for the requested use. See the Plan's *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12, for the product-specific definitions of experimental or investigational treatment.

Polysomnography is the gold standard for the diagnosis, assessment, and management of sleep disorders, including obstructive sleep apnea. The Plan's clinical guidelines for sleep studies are NOT included in this Plan policy. Plan guidelines for sleep studies are outlined in the following documents (rather than this Plan policy): the Plan's *Prior Authorization CPT Code Look-up Tool* and *Prior Authorization HCPCS Code Look-up Tool* (sorted by applicable, industry-standard CPT or HCPCS coding for the specified sleep study), the *Prior Authorization/Notification Requirements Matrix* categorized by service type, and the Plan's *Sleep Studies* reimbursement policies.

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Clinical Criteria

The Plan considers actigraphy testing experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of testing when used as a stand-alone method for the diagnosis, evaluation, and/or management of sleep disorders or for any other indication.

Limitations and Exclusions

The Plan considers actigraphy testing experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of testing when used as a stand-alone method for the diagnosis, evaluation, and/or management of sleep disorders or for any other indication.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, CMS NCD 240.4.1 includes nationally covered indications for sleep testing for obstructive sleep apnea and LCA A53019 includes guidelines for polysomnography and sleep studies. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria and Limitation and Exclusions sections of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines.

Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Code Considered Experimental and Investigational
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording) Plan note: Code used for stand-alone actigraphy testing only. (This code is NOT applicable for other sleep testing monitors that may use an actigraphy algorithm as a component of the device to identify periods of sleep and wakefulness.) The Plan considers actigraphy testing experimental and investigational when used as a stand-alone method for the diagnosis, evaluation, and/or management of sleep disorders or for any other indication.

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National Institutes of Health. National Heart, Lung, and Blood Institute. Sleep Apnea.

National Institutes of Health. National Heart, Lung, and Blood Institute. Sleep Studies. Also known as Polysomnography.

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 02/24/09: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 02/24/09: Utilization Management Committee (UMC) 03/25/09: Quality Improvement Committee (QIC)	06/01/09 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date of the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
02/01/10	Updated references and coding.	Version 2	02/22/10: MPCTAC 03/24/10: QIC
02/01/11	Updated references.	Version 3	02/16/11: MPCTAC 03/23/11: QIC
02/01/12	Updated references.	Version 4	02/28/12: MPCTAC 03/28/12: QIC
08/01/12	Updated references and code definition. Revised language in the following sections: Summary, Clinical Guideline Statement, and Applicable Coding. Removed redundant text in Clinical Background Information section.	Version 5	08/15/12: MPCTAC 09/26/12: QIC
08/01/13	Review for effective date 10/01/13. Updated references.	10/01/13 Version 6	08/21/13: MPCTAC 09/19/13: QIC
09/01/14	Review for effective date 11/01/14. Updated	11/01/14	09/17/14: MPCTAC

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Policy Revisions History			
	References section.	Version 7	10/08/14: QIC
09/01/15	Review for effective date 11/01/15. Updated list of applicable products, including the removal of Commonwealth Care, Commonwealth Choice, and Employer Choice because the products are no longer available. Updated References section.	11/01/15 Version 8	09/16/15: MPCTAC 10/14/15: QIC
11/25/15	Review for effective date 01/01/16. Revised language in the Applicable Coding section.	01/01/16 Version 9	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
09/01/16	Review for effective date 11/01/16. Administrative changes only made to the Summary, Medical Policy Statement, Definitions, Applicable Coding, Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	11/01/16 Version 10	09/21/16: MPCTAC 10/12/16: QIC
09/01/17	Review for effective date 10/01/17. Updated Policy Summary, References, and References to Applicable Laws and Regulations sections.	10/01/17 Version 11	09/20/17: MPCTAC
09/01/18	Review for effective date 10/01/18. Updated References and Other Applicable Policies sections.	10/01/18 Version 12	09/19/18: MPCTAC
09/01/19	Review for effective date 10/01/19. Administrative changes made to the Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	10/01/19 Version 13	09/18/19: MPCTAC
07/01/20	Review for effective date 08/01/20. Updated the References section.	08/01/20 Version 14	07/15/20: MPCTAC
08/01/21	Review for effective date 09/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, and References sections.	09/01/21 Version 15	08/27/21: MPCTAC (electronic vote)
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Applicable Coding, and References sections.	12/01/21 Version 16	11/17/21: MCPTAC

Next Review Date

07/01/22

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Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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