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2027

UNATTENDED SLEEP TESTING CODES FAQS

Table of Contents

I. Background 1
II. Channels and Parameter Categories 3
III. Sleep Team 4
IV. Payers 5
V. Industry and Device Companies 6
VI. Implementation and Operations 8

Service level	Technical Service	Interpretation and Report	Channels	Parameter Categories
Low complexity	95843	95847	3–4	3–5
Moderate complexity	95844	95848	5–10	6–8
High complexity	95846	95849	11 or more	9 or more

The technical codes describe setup, data acquisition, and technical analysis. The professional codes describe interpretation and reporting by a physician or other qualified health care professional, or QHP. Complexity is determined using the lower level supported by the number of clinically relevant channels and the number of clinically relevant parameter categories.

I. Background

What is changing for unattended sleep testing in CPT 2027?

CPT 2027 restructures unattended sleep testing from a bundled coding model to a component-based model. Codes 95800, 95801, and 95806 are deleted and replaced by six codes: 95843, 95844, 95846, 95847, 95848, and 95849. The new structure separates technical services from physician or other QHP interpretation and reporting.

Why were the unattended sleep testing codes revised?

The original codes were based on limited testing scenarios and did not adequately describe the configurations, data elements, or clinical applications of contemporary unattended sleep studies performed outside a sleep laboratory. The revised family is intended to better reflect physiologic monitoring scope, channel count, analytical requirements, and the clinical work involved.

Which existing codes are being deleted?

Codes 95800, 95801, and 95806 are deleted for CPT 2027. G codes G0398, G0399, and G0400 are also deleted for 2027.

Which new codes replace the deleted codes?

The replacement code family consists of:

- **95843:** Low-complexity technical service
- **95844:** Moderate-complexity technical service

- **95846:** High-complexity technical service
- **95847:** Low-complexity interpretation and report
- **95848**: Moderate-complexity interpretation and report
- **95849:** High-complexity interpretation and report

What is the difference between the technical and professional codes?

Codes 95843, 95844, and 95846 describe setup, data acquisition, and technical analysis, including the nonphysician resources and operational support associated with performing the study.

Codes 95847, 95848, and 95849 describe the physician or other QHP's interpretation and report.

Are the codes reported as bundled global services?

No, the technical component and professional services are now reported separately.

What determines whether a study is low, moderate, or high complexity?

Complexity is based on two factors:

1. **The number of clinically relevant channels recorded.**
2. **The number of clinically relevant parameter categories generated and analyzed.**

The lower of those two levels determines code selection.

What is the "lowest level" rule?

The channel count and parameter-category count are evaluated separately. If they fall into different complexity levels, the lower level of the two determines the complexity. A study cannot be coded at the higher level unless both measures support that level.

Can the technical and professional components be reported at different complexity levels?

No, not for the same unattended sleep study. When you report both components, the associated technical and professional codes should report the same complexity level because both are based on the same underlying channels and parameter categories.

Can code selection be based on everything a device is capable of measuring?

Code selection is based on the clinically relevant data measured by the device AND the data that is reviewed by the clinician. Therefore, extra channels or parameters that do not provide clinically relevant information do not justify a higher-level code.

Are prescreening and consumer-grade devices included?

No. Do not report the new codes for prescreening or consumer-grade devices.

II. Channels and Parameter Categories

What is a channel?

A channel is a data-collection pathway that monitors and displays a physiological signal during sleep. To count for coding, the channel must capture physiologic information that is clinically relevant to the sleep disorder being evaluated and that is viewed over the course of the study.

What are examples of channels?

Examples include airflow, oxygen saturation, pulse rate, position, movement tracking, mandibular movement, EEG, EOG, EMG, snore, photoplethysmography, heart rate variability, respiratory effort, ECG, RIP flow, and peripheral arterial tonometry. These are examples rather than an exhaustive list.

Does every raw signal collected by the device count as a channel?

Not necessarily. The signal must constitute a clinically relevant data-collection pathway and provide physiologic information relevant to the disorder being evaluated. Data that are collected but are not clinically relevant should not be used to increase the complexity level.

What is a parameter category?

A parameter category groups parameters that describe the same disorder or physiologic process. For example, AHI, RDI, and pAHI are grouped in one obstructive respiratory category because they describe obstructive breathing events or patterns.

What are examples of parameter categories?

Examples include sleep summary, sleep stages, oxygen summary, OSA respiratory indices, non-OSA respiratory indices, cardiac indices, movement indices, seizure indices, positional indices, arrhythmia indices, and carbon dioxide indices.

Do AHI, RDI, and REI count as three parameter categories?

No. Multiple measures within the same category, such as AHI, RDI, and REI, count as one parameter category.

What is a direct measure of sleep?

A direct measure identifies sleep stages using EEG, EOG, and EMG channels.

What is a derived measure of sleep?

A derived measure extrapolates sleep stages from signals other than EEG, EOG, and EMG.

Does one channel necessarily generate only one parameter category?

No. There is no one-to-one relationship between channels and parameter categories. Instead, it treats channel count and parameter-category count as two separate measures that must each be evaluated when determining study complexity.

A single channel may contribute information to one or more parameter categories, and multiple channels may work together to generate a single parameter category. The key consideration is not the number of outputs generated, but whether the study produces distinct, clinically relevant parameter categories.

Must each parameter category provide unique clinical information?

Yes. Each counted category must provide distinct clinical information. Duplicative outputs describing the same physiologic process should not be counted as separate categories merely because they have different names.

III. Sleep Team

What steps should a provider or coder use to select the correct code?

1. **Identify all clinically relevant channels recorded.**
2. **Identify all clinically relevant parameter categories generated.**
3. **Assign a complexity level to the channel count.**
4. **Assign a complexity level to the parameter-category count.**
5. **Use the lower complexity level.**
6. **Select the corresponding technical and/or professional code.**

What work is included in the technical service?

The procedural descriptions include reviewing the testing request, determining the test to be performed, setting up the equipment, instructing the patient, opening the returned recording, assessing recording time and technical and signal quality, reviewing and manually scoring the record, reviewing post-study feedback, preparing the study-data report, and making the data available to the interpreting physician or QHP.

What is technical analysis?

Technical analysis is the review, quality assessment, and scoring of data produced by the sleep testing device by a technologist or QHP.

What work is included in the professional interpretation?

Interpretation includes reviewing the recorded channels epoch by epoch; assessing recording time, technical quality, signal quality, and study adequacy; modifying scoring when necessary; assessing relevant events and sleep patterns; correlating the findings with clinical history and prior studies; reviewing post-study feedback; considering the information in medical decision-making; and completing the interpretation and report.

Is merely signing an automated report sufficient to support 95847–95849?

No, these codes describe active physician or QHP review of clinical information and recorded channels, an assessment of study quality, modification of scoring when necessary, clinical correlation, medical decision-making, and completion of the interpretation.

Must the physician or QHP review the recording epoch by epoch?

Yes. The definitions of interpretation and the professional procedural descriptions include epoch-by-epoch review of the recording.

Who may perform the interpretation?

The professional codes describe interpretation and reporting by a physician or other qualified health care

professional. Whether a particular practitioner qualifies to report a service may also depend on CPT requirements, scope-of-practice law, credentialing, and payer policy.

Requirements for interpreting sleep studies vary by insurer. Some payers allow board-eligible physicians to interpret studies without being over-read by a board-certified physician. Physicians without board certification in sleep medicine should check with each insurance provider they work with to determine if they can interpret sleep studies without being over-read. Requirements for interpretation of sleep studies vary by payer policy, state law, and accreditation requirements. Some insurers may specify qualifications for interpreting physicians, including board certification in sleep medicine. Physicians should verify applicable payer requirements and state licensure laws, as well as any facility accreditation standards, to determine whether they are eligible to interpret sleep studies and bill for those services.

What documentation should support code selection?

At minimum, the record should allow the reporting entity to identify the clinically relevant channels, clinically relevant parameter categories, technical quality and adequacy assessment, scoring or technical analysis performed, and, for professional services, the physician or QHP's interpretation and report. This documentation directly follows the elements used to select and describe the codes.

Should a device specification sheet alone determine the billed complexity?

No. A specification sheet may help identify device capabilities, but complexity cannot be assigned solely from those capabilities. Coding must reflect the clinically relevant channels and parameter categories associated with the actual study.

What if one or more expected channels fail during the study?

Code selection should reflect clinically relevant data derived or measured by the study and requires assessment of recording time, technical quality, signal quality, and study adequacy. Therefore, the completed recording, rather than the intended device configuration alone, must be evaluated.

What if the recording is technically inadequate?

The current AASM guidelines state that home sleep apnea testing requires at least 4 hours of technically adequate data, specifically oximetry and respiratory flow (or surrogate) signals. However, for this and all other unattended sleep testing, verifying requirements with individual payers is ideal, as payer requirements may differ.

Can you increase the code level by activating additional sensors?

The code level should not be increased unless those channels provide clinically relevant information and generate the necessary number of distinct, clinically meaningful parameter categories. Additional sensors or outputs do not independently justify higher-complexity reporting.

IV. Payers

Will payer systems be updated for 2027?

The legacy codes 95800, 95801, and 95806 are deleted and replaced with technical and professional codes differentiated by study complexity. These new codes will go into effect January 1, 2027. Payer systems will, therefore, need to recognize the new code family and its component-based structure.

Should all six new codes have identical coverage criteria?

Payers should distinguish coding eligibility from medical-necessity and benefit-coverage determinations and should base any coverage policy on applicable clinical evidence-based guidance and policy requirements.

What information could a payer request to validate the complexity level?

Relevant information could include the clinically relevant channels recorded, parameter categories generated, technical-quality assessment, and the interpretation report. These elements are central to code selection and performance of the service.

Do the new codes establish medical necessity for every unattended study?

No. CPT coding identifies and describes services not payer coverage or medical-necessity standards. A correctly selected code does not, by itself, guarantee coverage or payment.

Could prior authorization forms need revision?

Potentially. Forms built around the deleted bundled codes may no longer capture the new distinction between technical and professional services or the channel and parameter-category complexity levels.

V. Industry and Device Companies

Should a manufacturer state that a specific code be used for their device?

Code assignment is not based solely on a device model or capability. The reporting entity must evaluate the clinically relevant channels and parameter categories generated in the individual study.

What information should device companies provide to customers?

To support accurate assessment, product materials should clearly identify the physiological signals recorded, associated channels, outputs generated, physiologic domains represented, and circumstances in which a signal or output may be unavailable. However, manufacturers should avoid presenting that information as a guarantee of code selection because coding depends on the clinically relevant channels and parameter categories of a completed study.

Should device documentation distinguish raw signals from derived outputs?

Yes. The revised framework evaluates channels and parameter categories separately and distinguishes direct measures of sleep from derived measures. Clear documentation can help customers avoid treating every generated metric as a separate channel or parameter category.

Should manufacturers map every proprietary metric to a separate parameter category?

No. Multiple metrics that describe the same disorder or physiologic process remain within one category. Manufacturers should explain the clinical domain represented by a proprietary output rather than assuming each named metric counts separately.

Can a derived sleep-staging output be counted separately from direct sleep staging?

Not when the direct and derived measures represent the same physiologic domain. Those measures are not counted separately.

Would adding more sensors automatically increase code complexity?

No. Additional channels must provide clinically relevant information, and the study must also meet the corresponding parameter-category threshold. Device capability alone does not support higher-level coding.

How should an industry coding matrix be structured?

A useful matrix should separately display:

- Physiological signal or data pathway
- Corresponding channel
- Clinical relevance
- Reported output or parameter
- Parameter category
- Whether multiple outputs occupy the same category
- Typical data-availability limitations
- A disclaimer that final code selection depends on the actual completed study

This suggested structure reflects the separate treatment of channels, parameters, and clinical relevance.

Can a device company determine the professional interpretation code?

No. A manufacturer may provide factual information about device outputs, but the professional code depends on the clinically relevant study data and the interpretation and report performed by the physician or QHP.

Do automated scoring tools replace technical analysis?

No. Unreviewed automated scoring, by itself, does not fulfill the technical-analysis service.

Do automated reports replace physician or QHP interpretation?

No. The professional procedural descriptions require active review of the recording and clinical context, assessment of adequacy and quality, modification of scoring when necessary, analysis of study findings, clinical correlation, medical decision-making, and completion of the interpretation.

How should companies communicate coding information without guaranteeing reimbursement?

Materials should describe the code definitions and selection framework, explain that the lower of the channel and parameter-category levels should be used to determine complexity level for the test, and state that coverage and payment remain subject to final CPT guidance and payer policy. Companies should avoid statements that a product "is a 95844 device" or "guarantees" payment.

Could a single device support different codes in different studies?

Yes. Because coding depends on the clinically relevant channels and parameter categories generated in the actual study rather than solely on maximum device capability, studies performed with the same device could support different levels if the relevant data available for those studies differ.

VI. Implementation and Operations

What should sleep practices update before implementing the new codes?

Practices should review charge masters, order workflows, device inventories, scoring processes, interpretation templates, documentation fields, billing-system mappings, staff education, and payer policies.

What should be included in the technical analysis template?

A technical worksheet could include the channels successfully recorded, their clinical relevance, parameter categories generated, same-category outputs that were consolidated, study adequacy, recording time, signal quality, technical quality, scoring performed, and post-study feedback reviewed. These items align with the code-selection methodology and technical procedural descriptions.

What should be included in the professional report template?

The report should support the interpretation actually performed, including review of study adequacy and quality, relevant events and patterns, scoring modifications when necessary, correlation with clinical history and prior testing, post-study feedback, and the completed interpretation. The exact content will vary by study complexity and clinical findings.

Should practices create device-specific coding defaults?

A device-specific starting reference may help staff understand available signals, but it would conflict with the direction not to code from device capability alone. Any workflow should require confirmation of clinically relevant channels and parameter categories from the actual study.

What is the most important compliance safeguard?

The strongest safeguard to inaccurate coding is to prevent code selection from being driven by the device's marketed capability or the sheer number of raw outputs. The documented, clinically relevant channels and distinct parameter categories from the completed study should determine the complexity level, with the lower of the two levels determining the final complexity level.


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