AASM American Academy of SLEEP MEDICINE®



BEHAVIORAL SLEEP MEDICINE CLAIMS DENIAL

NAVIGATION GUIDE

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Behavioral Sleep Medicine Claims Denial Navigation Guide

Navigating Claims, Appeals, and Reviews for Successful Reimbursement of Behavioral Sleep Medicine Services

I. Background

Purpose

Behavioral sleep medicine (BSM) services—including cognitive behavioral therapy for insomnia (CBT-I), interventions for circadian rhythm disorders, PAP adherence support, and other behavioral treatments—are well-supported by clinical evidence and are increasingly integrated into comprehensive sleep care. However, despite their established role in improving outcomes, reimbursement for these services remains inconsistent due to variability in payer policies, benefit structures, and coding pathways.

This guide is designed to help clinicians, sleep psychologists, and practice administrators navigate the full lifecycle of claims management—from pre-service verification through appeals and peer-to-peer reviews. It emphasizes practical, actionable strategies to reduce denials, strengthen documentation, and align billing practices with payer expectations, ultimately improving reimbursement success and reducing administrative burden.

Scope

This guide addresses reimbursement and claims management issues associated with behavioral sleep medicine services. It outlines key considerations related to coverage verification, prior authorization, coding, documentation, claims submission, denial management, appeals, and peer-to-peer review processes.

Denial Prevention

- Denial prevention begins before treatment is initiated and requires coordination among clinicians, administrative staff, and billing personnel.

- Behavioral sleep medicine benefits should be verified before services are rendered, including confirmation of whether services are covered under medical benefits, behavioral health benefits, or through a delegated behavioral health vendor.
- Prior authorization, referral, and utilization management requirements should be identified and satisfied before initiating treatment when required by the payer.
- Clinicians should establish and document a sleep-related diagnosis, functional impairment, treatment goals, and the clinical rationale for behavioral intervention.
- Documentation should clearly describe the specific behavioral sleep medicine services provided, including interventions such as cognitive behavioral therapy for insomnia (CBT-I), stimulus control, sleep restriction therapy, relaxation training, adherence interventions, or other evidence-based behavioral treatments.
- Coding should accurately reflect the services rendered and comply with applicable payer policies, CPT® coding guidance, and plan-specific billing requirements.
- Practices should verify clinician credentialing status and network participation requirements, particularly when services are billed under behavioral health benefits.
- Telehealth services should comply with payer-specific coverage, place-of-service, modifier, and licensure requirements when applicable.
- Patients should be informed of potential coverage limitations, benefit restrictions, cost-sharing obligations, prior authorization requirements, and non-covered services before treatment begins.
- Denial trends should be monitored periodically to identify recurring issues related to medical necessity, authorization requirements, coding, documentation, or benefit administration and to support continuous process improvement.

Verification of Behavioral Health Benefits

Before initiating behavioral sleep medicine treatment, practices should conduct a thorough benefits verification process to understand how services will be covered and adjudicated. Behavioral sleep medicine services often fall at the intersection of medical and behavioral health benefits, and coverage pathways can vary significantly between payers.

This process should include confirming whether the patient's plan covers psychotherapy or health and behavior services, identifying whether services must be billed through a separate behavioral health administrator, and determining network participation requirements. Failure to clarify these elements up front frequently leads to avoidable claim denials, particularly when services are submitted to the wrong payer or outside the appropriate network.

Practices should develop standardized workflows for benefit verification document verification findings and reference numbers obtained during payer communications and maintain payer-specific reference guides to ensure consistency across scheduling, billing, and clinical teams.

Prior Authorization

Prior authorization requirements for behavioral sleep medicine services vary widely across payers and are a frequent source of delays and denials if not addressed in advance. Services such as CBT-I, health and behavior interventions, psychological testing, and telehealth psychotherapy may require prior approval depending on the plan.

Obtaining authorization involves verifying whether services are subject to utilization management, identifying required documentation, confirming applicable visit limits, and ensuring that authorization is secured before treatment begins. Incomplete or missing authorizations often result in automatic denials, even when services are clinically appropriate.

Practices should establish clear pre-visit authorization protocols, designate responsibility for submission and tracking, and monitor payer timelines to prevent lapses in approval during ongoing treatment episodes.

Determine whether prior authorization is required for:

- CBT-I
- Health and Behavior Assessment and Intervention services
- Psychological testing
- Telehealth psychotherapy services

Refer to the AASM Prior Authorization Toolkit for resources to assist with obtaining Prior Authorization.

Documentation Requirements

Comprehensive documentation is essential to support both initial claim approval and any subsequent appeal. Payers typically require clear evidence that services are medically necessary, clinically appropriate, and consistent with accepted standards of care.

Documentation should clearly establish the patient's diagnosis of a sleep disorder, describe presenting symptoms and functional impairment, and outline a structured treatment plan with measurable goals. Progress notes should demonstrate ongoing clinical need, document specific behavioral interventions used (e.g., sleep restriction or stimulus control), and track the patient's response to treatment over time.

Incomplete or vague documentation, such as generic statements without clinical detail, is a common contributor to denials. Standardized documentation templates and clinician education can improve consistency and strengthen claim defensibility.

Documentation should include:

- ✓ Sleep disorder diagnosis
- ✓ Clinical symptoms
- ✓ Functional impairment
- ✓ Treatment goals
- ✓ Treatment plan
- ✓ Progress toward goals
- ✓ Evidence supporting medical necessity
- ✓ Clinical rationale for treatment
- ✓ Specific behavioral interventions provided
- ✓ Patient response to treatment

II. Common Reasons for Behavioral Sleep Medicine Claims Denials

Behavioral sleep medicine claims are often denied due to predictable and preventable issues related to coverage policies, coding, or documentation. These denials typically reflect misalignment between submitted claims and payer expectations, rather than a lack of clinical validity.

Understanding the most common denial categories—such as lack of medical necessity, diagnosis limitations, incorrect coding, and telehealth compliance gaps—allows practices to proactively address risks before claims are submitted. Each denial category requires targeted mitigation strategies, including improved documentation, payer-specific coding alignment, and verification of benefit structures.

By tracking denial trends internally and incorporating lessons learned into workflows, practices can significantly reduce repeat denials over time.

1. Lack of Medical Necessity

Description

The payer determines that behavioral treatment is not medically necessary.

Example

A clinician submits claims for CBT-I sessions, but the record contains only general sleep complaints and lacks documentation of chronic insomnia symptoms, daytime impairment, prior treatment attempts, or functional consequences.

Mitigation Tips

- Document insomnia duration.
- Document daytime impairment.
- Document impact on work, school, safety, or quality of life.
- Reference evidence-based treatment recommendations.

2. Diagnosis Not Covered

Description

The diagnosis submitted is not covered for the behavioral health service billed.

Example

CBT-I is billed using an insomnia diagnosis, but the payer limits psychotherapy coverage to specific mental health diagnoses.

Mitigation Tips

- Review payer coverage policies.
- Ensure diagnosis coding reflects the primary condition being treated.
- Verify medical versus behavioral health benefit pathways.

Common Behavioral Sleep Diagnoses

Diagnosis Code	Description
F51.01	Primary insomnia
F51.04	Psychophysiologic insomnia
G47.00	Insomnia, unspecified
G47.21	Delayed sleep-wake phase disorder
G47.26	Shift work sleep disorder
G47.33	Obstructive sleep apnea (when treating PAP adherence issues)

3. Incorrect CPT Coding

Description

Behavioral services are billed using codes inconsistent with documentation.

Example

A payer denies 90837 because documentation supports only a brief intervention.

Commonly Used CPT Codes

CPT Code	Description
90791	Psychiatric Diagnostic Evaluation
90834	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
96156	Health Behavior Assessment
96158	Health Behavior Intervention, individual
96159	Each additional 15 minutes
96164	Group Health Behavior Intervention
96165	Each additional group intervention unit

Mitigation Tips

- Match documentation to time requirements.
- Document treatment modality.
- Document start and stop times when required.

4. Telehealth Denials

Description

Claims are denied because telehealth requirements were not met.

Example

A CBT-I session is delivered virtually but submitted without the required modifier or place-of-service designation.

Mitigation Tips

- Verify payer-specific telehealth rules.
- Use appropriate modifiers.
- Document patient consent and telehealth platform.

5. Behavioral Health Carve-Out Issues

Description

Claims are submitted to the medical payer when behavioral health claims must be processed through a delegated behavioral health vendor.

Example

The insurer delegates behavioral health claims administration to a third-party behavioral health organization, resulting in denial.

Mitigation Tips

- Verify benefit administrator before treatment.
- Maintain payer-specific billing workflows.

6. Frequency Limit Exceeded

Description

The payer limits the number of psychotherapy or behavioral intervention visits.

Example

A patient requires additional CBT-I sessions after reaching the payer's annual limit.

Mitigation Tips

- Track visit utilization.
- Request exceptions when clinically justified.
- Document continued medical necessity.

7. Out-of-Network Provider

Description

The clinician is not credentialed with the behavioral health network.

Example

A sleep psychologist participates in the medical network but not the behavioral health network.

Mitigation Tips

- Verify participation status with both networks.
- Maintain credentialing records.

8. Health and Behavior Code Denials

Description

The payer does not recognize or improperly processes Health and Behavior Assessment/Intervention codes, or denies the service because the diagnosis code does not meet the payer's coverage requirements for Health and Behavior services.

Example

A CBT-I program bills 96156 and 96158, for a patient with a qualifying medical sleep disorder,but the payer incorrectly classifies the service as psychotherapy. Alternatively, the claim is denied because the payer does not recognize the submitted diagnosis as supporting Health and Behavior services.

Mitigation Tips

- Include supporting documentation linking the behavioral intervention to the underlying medical condition
- Verify the diagnosis supports use of Health and Behavior codes under payer policy.
- Cite payer policy language when available.
- Appeal denials that misclassify services.

9. Documentation Insufficiency

Description

Documentation fails to support billed services.

Example

Progress notes indicate "sleep counseling provided" but do not describe the interventions performed.

Mitigation Tips

Document:

- Sleep restriction therapy
- Stimulus control
- Cognitive restructuring
- Sleep hygiene interventions
- Treatment response
- Homework assignments
- Duration of service
- Time spent when required
- Progress toward treatment goals

10. Experimental or Investigational Denial

Description

The payer incorrectly classifies CBT-I or digital behavioral interventions as investigational.

Example

A claim for digital CBT-I supported by clinician oversight is denied as experimental.

Mitigation Tips

- Submit supporting literature.
- Cite clinical practice guidelines.
- Include evidence supporting CBT-I as first-line therapy for chronic insomnia.

III. Claims Appeals

Behavioral sleep medicine clinicians and practices should consider pursuing a formal claims appeal when a denial appears inconsistent with the patient's clinical presentation, the documentation submitted, the services provided, or the payer's stated coverage criteria. Appeals are especially important in behavioral sleep medicine because denials may arise from payer misunderstanding of the role of evidence-based behavioral interventions in sleep care, misclassification of services under the wrong benefit category, or automated claim edits that do not fully account for the clinical rationale documented in the medical record. Rather than treating a denial as a final determination, practices should review the explanation of benefits or remittance advice carefully, identify the specific reason for denial, and determine whether the denial resulted from a billing or administrative error that can be corrected and resubmitted, or whether a formal appeal supported by additional documentation is warranted.

Appeals should be considered when CBT-I is denied as not medically necessary, particularly when the patient has a documented diagnosis of chronic insomnia, functional impairment, and a treatment plan that supports the use of CBT-I as an evidence-based intervention. In these cases, the appeal should clearly connect the patient's symptoms, duration of sleep disturbance, daytime consequences, and prior treatment history to the clinical need for behavioral treatment. Appeals may also be appropriate when Health and Behavior Assessment and Intervention codes are incorrectly denied or misclassified, especially when the service addressed behavioral factors affecting a diagnosed medical condition rather than a primary mental health condition. Similarly, telehealth denials should be reviewed when the practice complied with the payer's requirements, such as using the appropriate modifier, documenting patient consent, and identifying the correct place of service. Practices should also appeal denials in which behavioral sleep services are misclassified as non-covered despite being tied to a documented sleep disorder, as well as denials related to frequency limits when additional sessions are clinically justified and continued treatment is supported by measurable progress or ongoing medical necessity.

Supporting documentation should include:

- Initial evaluation
- Treatment plan
- Progress notes
- Sleep diary summaries
- Relevant clinical practice guidelines
- Published evidence supporting CBT-I effectiveness
- Denial notice, explanation of benefits (EOB), or remittance advice
- Prior authorization documentation (if applicable)
- Sleep study results (when relevant)
- Benefit verification records (when applicable)

Tips for Behavioral Sleep Medicine Appeal Letters

1. **Describe the sleep disorder diagnosis.**
2. **Describe clinical impairment.**

3. **Explain why behavioral treatment is medically necessary.**
4. **Explain why the selected CPT code is appropriate.**
5. **Reference supporting clinical practice guidelines.**
6. **Request reconsideration of payment.**

Practices should monitor appeal outcomes and maintain successful appeal templates to support consistent responses to recurring denial types.

Tips for Peer-to-Peer Reviews

Peer-to-peer reviews are particularly valuable when:

- CBT-I is denied for lack of medical necessity.
- Visit limits are exceeded.
- Digital CBT-I programs are denied.
- Health and Behavior codes are misclassified.
- Telehealth services are questioned.

Key Discussion Points

- CBT-I is the first-line treatment for chronic insomnia.
- Treatment improves clinical outcomes and reduces healthcare utilization.
- Behavioral treatment may reduce reliance on sedative-hypnotic medications.
- Services are evidence-based and clinically appropriate.

IV. Behavioral Sleep Medicine Documentation Checklist

☐ Diagnostic evaluation completed
☐ Sleep disorder diagnosis documented
☐ Functional impairment documented
☐ Treatment goals established
☐ CBT-I components documented
☐ Treatment response documented
☐ Medical necessity supported
☐ Time requirements documented
☐ Telehealth requirements documented
☐ Follow-up plan documented

V. CBT-I Reimbursement Pathways

One of the most significant challenges in behavioral sleep medicine reimbursement is determining the appropriate billing pathway. Depending on the clinician's credentials, payer policies, and clinical circumstances, CBT-I may be billed using psychotherapy codes, Health and Behavior Assessment and Intervention (HBAI) codes, or evaluation and management (E/M) services when provided by a physician or advanced practice provider.



Common Billing Pathways

Psychotherapy Codes

Psychotherapy codes are typically used when insomnia is treated as a mental or behavioral health condition and services are provided by a licensed psychologist or other qualified behavioral health clinician.

CPT Code	Description
90791	Psychiatric Diagnostic Evaluation
90832	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90846	Family Psychotherapy without Patient
90847	Family Psychotherapy with Patient

Health and Behavior Assessment and Intervention (HBAI) Codes

HBAI codes may be appropriate when behavioral factors are affecting a diagnosed medical condition, such as obstructive sleep apnea, circadian rhythm sleep-wake disorders, or insomnia associated with a medical condition.

CPT Code	Description
96156	Health Behavior Assessment
96158	Individual Health Behavior Intervention, first 30 minutes
96159	Each additional 15 minutes
96164	Group Health Behavior Intervention
96165	Each additional group intervention unit

Evaluation and Management (E/M) Services

Sleep physicians and advanced practice providers providing behavioral interventions as part of a comprehensive sleep medicine visit may bill appropriate E/M services based on medical decision-making or total time. Documentation should clearly support the medical necessity of the visit, the services provided, and the elements used to select the reported E/M level.

Key Considerations

- Verify whether the payer recognizes HBAI codes.
- Confirm whether services fall under medical or behavioral health benefits.
- Determine whether the payer requires mental health diagnoses for psychotherapy reimbursement.
- Understand telehealth requirements for each billing pathway.
- Maintain documentation supporting the selected coding approach.

Common Payer Policies Affecting Sleep Psychologists

Behavioral sleep medicine services frequently encounter payer policies that were not designed specifically for sleep disorders. Understanding these policies can help practices proactively prevent denials.

VI. Medical vs. Behavioral Health Benefit Classification

Coverage pathways for behavioral sleep medicine services vary considerably among payers. Some payers administer treatment for insomnia and other sleep-related behavioral conditions through behavioral health benefits, while others process services through medical benefits. In some cases, coverage determinations may depend on the diagnosis code, provider type, service code, or the payer's internal benefit design.

Failure to identify the appropriate benefit category before treatment begins can result in claim denials, payment delays, unexpected patient financial responsibility, or referral to a different provider network. Prior to initiating treatment, practices should verify how behavioral sleep medicine services will be adjudicated and document guidance received from the payer.

Potential challenges associated with benefit classification include:

- **Different deductibles and cost-sharing obligations.** Behavioral health benefits may have separate deductibles, copayments, coinsurance requirements, or out-of-pocket maximums from medical benefits. Patients should be informed of potential financial responsibility before services are rendered.
- **Separate authorization and utilization management requirements.** Behavioral health services may be subject to different prior authorization, treatment plan review, or visit limitation requirements than medical services. Authorization requirements should be verified before treatment initiation and monitored throughout the course of care.
- **Separate provider networks.** Some health plans utilize a delegated behavioral health organization or carve-out vendor that maintains its own contracted provider network. A clinician who is in-network under the medical benefit may be considered out-of-network for behavioral health services.
- **Different reimbursement methodologies and payment rates.** Reimbursement may vary based on whether services are processed through medical or behavioral health benefits, including differences in fee schedules, covered services, allowable billing codes, and visit limitations.
- **Coverage limitations and visit caps.** Some plans impose annual visit limits, episode-of-care restrictions, medical necessity reviews, or requirements for ongoing authorization when services are billed under behavioral health benefits.
- **Provider credentialing requirements.** Certain payers may require clinicians to be credentialed under behavioral health networks or meet profession-specific participation requirements before reimbursement will be issued.
- **Claims routing and billing requirements.** Behavioral health claims may need to be submitted to a separate payer entity, behavioral health administrator, or claims processing vendor. Submission to the incorrect entity can result in administrative denials.

Best practice: Before the first visit, verify whether behavioral sleep medicine services will be covered under medical benefits, behavioral health benefits, or a delegated behavioral health program. Document the payer representative's guidance, reference number (if provided), authorization requirements, network status, and any applicable coverage limitations to reduce the risk of avoidable denials.

Visit Limitations

Many health plans impose utilization limits on psychotherapy and behavioral health services, which can affect coverage for behavioral sleep medicine treatment. While CBT-I and other behavioral interventions are often delivered over a defined course of treatment, payers may place restrictions on the number of covered visits or require additional review as treatment progresses. Failure to monitor these limitations can result in claim denials, retrospective payment recoupment, or unexpected patient financial responsibility.

Examples of visit limitation policies include:

- **Annual or lifetime visit limits.** Plans may limit the number of psychotherapy or behavioral health visits covered during a calendar year, benefit year, or lifetime benefit period. Limits may apply to all behavioral health services combined or to specific service categories.
- **Authorization requirements after a predetermined number of visits.** Initial visits may be covered without prior authorization, but additional sessions may require submission of a treatment plan, progress report, or authorization request after a specified threshold has been reached.
- **Medical necessity reviews.** Payers may require periodic review of treatment progress after a defined number of sessions to determine whether continued treatment remains medically necessary. Requests for continued care may require updated clinical documentation demonstrating ongoing symptoms, functional impairment, treatment response, and the rationale for additional visits.
- **Episode-of-care limitations.** Some payers define an approved course of treatment for behavioral health services and require reauthorization or reassessment before additional services are covered.
- **Frequency limitations.** Certain plans may restrict the number of psychotherapy services that can be billed within a specific time period (e.g., per week or per month) or may limit reimbursement for multiple behavioral health services on the same date of service.
- **Telehealth-specific limitations.** Although many plans cover telehealth behavioral health services, some may apply different visit limits, authorization requirements, or reimbursement policies to virtual care.

Best Practice: Practices should verify visit limitations, authorization requirements, and medical necessity review thresholds before treatment begins and periodically throughout the course of care. Tracking cumulative visits and authorization expirations can help avoid interruptions in treatment and reduce the risk of denials related to benefit exhaustion or unauthorized services. Documentation should clearly demonstrate ongoing clinical need, progress toward treatment goals, and the justification for continued behavioral sleep medicine services when additional visits are requested.

VII. Telehealth Restrictions

Telehealth has expanded access to behavioral sleep medicine services, particularly for patients in areas with limited access to sleep psychologists and other behavioral sleep medicine providers. However, coverage and billing requirements for telehealth services vary significantly across payers and may differ from those applicable to in-person services. Failure to comply with telehealth-specific requirements can result in denials, reduced reimbursement, or post-payment recoupment.

Practices should verify telehealth coverage requirements before services are rendered and periodically review payer policies, as telehealth rules continue to evolve.

Payer policies may vary regarding:

- **Audio-only services.** Some payers cover psychotherapy or behavioral health services provided via audio-only technology, while others require real-time audio and video communication. Coverage may be limited to specific circumstances, such as lack of access to video technology, documented patient barriers, or designated service codes. Claims submitted for audio-only services when video is required may be denied as non-covered services or billed incorrectly.
- **Patient location requirements.** Certain payers require the patient to be physically located in a specific state, geographic region, or approved originating site at the time of service. Coverage may also depend on where the clinician is located when services are rendered. Failure to meet payer-specific location requirements or state licensure requirements can result in claim denials.
- **Telehealth modifiers and place-of-service requirements.** Payers may require specific modifiers and place-of-service (POS) codes to identify telehealth services. Requirements may vary among payers and may differ based on whether services are delivered via audio-video or audio-only technology. Incorrect or missing modifiers are a common source of telehealth-related claim denials.
- **Covered clinician types.** Not all payers recognize the same provider types for telehealth reimbursement. Coverage policies may differ for psychologists, physicians, advanced practice clinicians, licensed counselors, clinical social workers, and other behavioral health professionals. A telehealth service that is covered when performed by one clinician type may not be reimbursable when provided by another.
- **Documentation requirements:** Payers may require specific telehealth documentation elements, such as patient consent for telehealth services, the technology platform used, whether the service was delivered via audio-video or audio-only communication, and the locations of the patient and clinician at the time of service. Incomplete documentation may create challenges during claim review, payment audits, or appeal processes.

Additional telehealth-related challenges may include:

- **Differences between medical and behavioral health telehealth policies.** Behavioral sleep medicine services may be administered through a payer's behavioral health benefit while other sleep medicine services are processed through the medical benefit. Telehealth coverage rules, authorization requirements, and reimbursement rates may differ between these benefit structures.
- **Prior authorization requirements.** Some plans require authorization for telehealth-delivered behavioral health services even when the equivalent in-person service does not require prior authorization. Authorization requirements may also vary based on clinician type, diagnosis, or treatment duration.
- **Network participation requirements.** A clinician may be credentialed and contracted for in-person services but not approved to provide telehealth services under a particular payer contract or behavioral health network.

- **Interstate licensure considerations.** Payers may require clinicians to be licensed in the state where the patient is located at the time of service. Services provided across state lines without appropriate licensure or telehealth authorization may be subject to denial.
- **Documentation requirements.** Many payers require documentation of patient consent for telehealth, the modality used (audio-video or audio-only), patient and clinician locations, and confirmation that telehealth requirements were met. Incomplete documentation may lead to denials during claim review or audit.
- **Reimbursement parity issues.** Payment rates for telehealth behavioral health services may differ from in-person services depending on payer policy, contract terms, and applicable state requirements. Practices should understand reimbursement methodologies before initiating treatment through telehealth.

Best Practice: Before initiating telehealth behavioral sleep medicine services, verify patient eligibility, network status, authorization requirements, covered clinician types, telehealth billing rules, and applicable state licensure requirements. Documentation should clearly identify the telehealth modality used, patient location, clinician location, patient consent, and clinical rationale for services provided. Establishing and following standardized telehealth billing workflows can help reduce avoidable denials and ensure compliance with payer-specific requirements.

VIII. Health and Behavior Code Recognition

Health and Behavior Assessment and Intervention (HBAI) services are designed to address the behavioral, psychological, and psychosocial factors that affect the prevention, treatment, or management of a medical condition. Although HBAI services may be clinically appropriate for many behavioral sleep medicine interventions, payer recognition and reimbursement of these codes varies considerably. Some payers recognize and routinely reimburse HBAI services, while others have limited coverage policies, require specific provider types, or do not recognize the codes at all.

Because behavioral sleep medicine often falls at the intersection of medical and behavioral health care, practices may encounter challenges determining whether HBAI services or traditional psychotherapy services represent the appropriate billing pathway. Failure to verify payer requirements before treatment begins may result in denials, payment delays, or administrative burden associated with appeals and claim resubmissions.

Common denial reasons include:

- **"Non-covered service."** Some payers do not cover HBAI services or exclude specific HBAI codes from their fee schedules. Claims may be denied even when the underlying service is clinically appropriate and medically necessary.
- **"Incorrect code type."** Payers may determine that the service should have been billed using psychotherapy codes rather than HBAI codes, or vice versa. This frequently occurs when payer policies do not clearly distinguish between behavioral interventions addressing a medical condition and services addressing a primary mental health diagnosis.
- **"Behavioral health services not covered under medical benefits."** Some payers classify behavioral sleep medicine services as behavioral health services and deny claims submitted through the medical benefit, requiring submission through a behavioral health administrator or delegated behavioral health vendor.

Additional challenges may include:

- **Variation in payer recognition of HBAI codes.** Coverage policies may differ significantly among commercial payers, Medicare Advantage plans, Medicaid programs, and other payers. A code that is routinely reimbursed by one payer may be denied by another.
- **Diagnosis-related limitations.** Some payers require a primary medical diagnosis to support HBAI services and may deny claims when the diagnosis submitted is perceived to represent a behavioral health condition rather than a medical disorder. Practices should verify diagnosis requirements and coverage policies before billing.
- **Confusion regarding insomnia treatment pathways.** Payers may differ in how they classify treatment for chronic insomnia. Some consider CBT-I and related interventions eligible for reimbursement under behavioral health benefits, while others may allow reimbursement through medical benefits using HBAI services. Misalignment between the payer's classification and the submitted claim can lead to denials.
- **Provider eligibility restrictions.** Certain payers restrict reimbursement of HBAI services to specific clinician types or require particular credentialing arrangements. A service that would otherwise be covered may be denied if performed by a provider who does not meet payer-specific requirements.
- **Authorization and utilization management requirements.** Some plans require prior authorization, medical necessity review, or treatment plan submission for HBAI services. These requirements may differ from those applied to psychotherapy services or other behavioral health benefits.
- **Medical necessity challenges.** Payers may request documentation demonstrating how the behavioral intervention is intended to improve the management of a diagnosed medical condition and why the services are clinically appropriate. Incomplete documentation may increase the likelihood of denial.
- **System and claims processing limitations.** Some claims processing systems may not consistently recognize HBAI codes, resulting in administrative denials, requests for additional information, or incorrect routing of claims to behavioral health departments for review. In some cases, claims may be automatically routed to a behavioral health administrator, suspended for manual review, or denied pending additional documentation.

Best Practice: Before initiating treatment, verify whether the payer recognizes and reimburses HBAI services, determine whether services should be billed under medical or behavioral health benefits, and confirm any authorization, diagnosis, provider eligibility, or documentation requirements. Practices should maintain records of payer guidance received during benefits verification and monitor denials involving HBAI services to identify payer-specific billing patterns and appeal opportunities.

IX. Digital Therapeutics and Digital CBT-I

Digital cognitive behavioral therapy for insomnia (digital CBT-I) and other prescription or non-prescription digital therapeutics have emerged as important tools for improving access to evidence-based behavioral sleep medicine treatment. These programs may be delivered independently, used as part of a clinician-guided treatment plan, or integrated within broader sleep medicine services. Despite growing clinical adoption, payer coverage policies remain highly variable and continue to evolve.

Coverage and reimbursement challenges often arise because digital therapeutics do not fit neatly within traditional reimbursement structures for medical, behavioral health, pharmacy, or durable medical equipment. As a result, practices may encounter inconsistent coverage determinations, varying authorization requirements, and differing payer interpretations regarding medical necessity and clinical effectiveness.

Payers may:

- **Cover clinician-guided digital CBT-I programs.** Some payers are more likely to reimburse digital CBT-I when the program is prescribed, monitored, or integrated into the care plan of a qualified clinician. Coverage may be contingent upon documented clinician involvement, ongoing oversight, or documented treatment outcomes.
- **Exclude standalone digital therapeutics.** Certain plans may not cover self-directed digital CBT-I programs or digital therapeutics delivered without direct clinician involvement, even when substantial clinical evidence supports their use.
- **Require prior authorization.** Coverage may be conditioned on demonstrating medical necessity, previous treatment failure, symptom severity, or compliance with specific utilization management requirements. Authorization criteria may differ substantially among payers.
- **Classify programs as investigational, experimental, or emerging technologies.** Some payers may determine that a digital therapeutic does not meet the plan's coverage criteria despite published evidence supporting its effectiveness, resulting in denials based on investigational status.

Additional coverage challenges may include:

- **Inconsistent benefit classification.** Digital CBT-I programs may be processed under medical benefits, behavioral health benefits, pharmacy benefits, wellness benefits, or separate digital health programs depending on the payer. Identifying the correct benefit pathway can be difficult and may require coordination among multiple payer departments.
- **Delegated behavioral health vendor requirements.** Coverage decisions for digital CBT-I may be administered through a delegated behavioral health organization rather than the medical plan itself. Authorization requirements, provider eligibility criteria, covered products, and reimbursement policies may differ from those used under the medical benefit.
- **Lack of clearly established reimbursement pathways.** Some payers may support the clinical use of digital CBT-I but have not established specific reimbursement mechanisms, covered codes, or payment policies for these services.
- **Variable recognition of prescription digital therapeutics.** Coverage may differ depending on whether the product is prescription-based, FDA-authorized or FDA-cleared where applicable, employer-sponsored, or offered through a payer's preferred vendor arrangement.
- **Documentation and outcome reporting requirements.** Some payers may require evidence of patient engagement, adherence, symptom improvement, or clinician review before approving ongoing coverage or reimbursement.
- **Duplicate service concerns.** Claims may be denied if payers believe a digital therapeutic duplicates services already being provided through psychotherapy, health and behavior assessment and intervention (HBAI) services, care management programs, or other behavioral health treatment.
- **Coverage limitations based on diagnosis.** Certain plans may cover digital CBT-I only for specific diagnoses, patient populations, or treatment settings. Coverage criteria may not align with the full range of sleep disorders and behavioral sleep medicine conditions for which digital interventions may be clinically beneficial.
- **Employer- and plan-specific variability.** Coverage may differ not only across payers but also between health plans offered by the same insurer, creating challenges for practices attempting to establish standardized workflows.

Best Practice: Before recommending a digital CBT-I program or digital therapeutic, verify whether coverage exists and determine how the service will be adjudicated under the patient's benefit structure. Practices should confirm any authorization requirements, applicable billing pathways, patient cost-sharing obligations, and documentation expectations. When coverage is unclear, patients should be informed of potential out-of-pocket expenses before treatment is initiated. Maintaining documentation of payer guidance and coverage determinations may help support future appeals when coverage is denied.

Self-Guided Digital CBT-I Programs

In self-guided models, patients independently complete structured CBT-I modules through a web-based platform or mobile application. Programs typically deliver core CBT-I components, including sleep restriction therapy, stimulus control, cognitive restructuring, sleep education, and relapse prevention strategies without direct clinician involvement.

Self-guided programs may improve access to care for patients who face barriers such as geographic limitations, provider shortages, long wait times, transportation challenges, or scheduling constraints. However, reimbursement for these programs remains inconsistent.

Potential payer concerns include:

- Lack of clinician involvement. Some payers may view self-guided programs as educational or self-help resources rather than reimbursable medical services because there is limited or no direct interaction with a clinician.
- Classification as wellness services. Digital sleep improvement programs may be categorized as wellness, preventive health, or consumer-directed services rather than treatment for a diagnosed medical condition.
- Experimental or investigational determinations. Despite growing evidence supporting digital CBT-I effectiveness, some payers continue to classify certain digital therapeutics or digital CBT-I platforms as investigational, emerging technologies, or non-covered services.
- Limited claims submission pathways. In many cases, standalone self-guided digital programs may not have an established reimbursement mechanism under traditional medical or behavioral health benefits.
- Lack of established benefit pathways. Some payers may support behavioral sleep medicine treatment in general but have not established a specific benefit category, billing process, or reimbursement mechanism for self-guided digital CBT-I programs, leading to inconsistent coverage determinations.

Implementation considerations:

- Verify coverage before recommending a digital program.
- Inform patients of potential out-of-pocket costs.
- Document the clinical rationale for recommending digital CBT-I.
- Maintain records of payer coverage determinations when available.

Clinician-Supported Digital CBT-I Programs

Clinician-supported digital CBT-I combines technology-based treatment modules with professional oversight from a sleep physician, psychologist, behavioral sleep medicine clinician, or other qualified healthcare professional. Patients complete program activities between visits while clinicians monitor progress, reinforce treatment principles, address barriers to success, and modify treatment recommendations as necessary.

This model may be more likely to align with existing reimbursement pathways because clinician involvement contributes to clinical decision-making, treatment planning, and ongoing patient management.

Potential reimbursement pathways may include:

- Evaluation and Management (E/M) services when physician or qualified healthcare professional evaluation, treatment planning, and ongoing management activities meet applicable billing requirements.
- Psychotherapy services when clinically appropriate and consistent with payer requirements and provider scope of practice.
- Health and Behavior Assessment and Intervention (HBAI) services when interventions address behavioral factors affecting a diagnosed medical condition rather than a primary mental health diagnosis.
- Telehealth services when digital CBT-I support is delivered through covered telehealth encounters and all telehealth billing requirements are satisfied.

Implementation considerations:

- Establish a structured workflow for review of symptom data, sleep diaries, and treatment progress.
- Define clinician responsibilities for patient monitoring and intervention.
- Document all clinical decision-making and treatment recommendations.
- Verify authorization and coverage requirements prior to treatment initiation.

Integrated Sleep Program Models

In integrated care models, digital CBT-I is incorporated into a broader sleep medicine treatment plan and used alongside other sleep disorder interventions. Digital CBT-I may serve as an adjunct to physician management, PAP therapy, behavioral counseling, circadian rhythm interventions, or multidisciplinary sleep care.

These programs often position digital CBT-I as one component of an overall treatment strategy rather than a standalone intervention. This approach may be particularly beneficial when managing patients with multiple sleep disorders or when ongoing clinical oversight is required.

Documentation should clearly describe:

- Clinician oversight. The role of the treating clinician in selecting, prescribing, recommending, monitoring, or supervising digital CBT-I.
- Clinical decision-making. Why digital CBT-I was selected and how treatment decisions were individualized based on the patient's diagnosis, symptoms, treatment history, and response to care.
- Patient progress monitoring. Review of sleep diaries, symptom assessments, adherence data, patient-reported outcomes, and ongoing treatment response.
- Treatment modifications. Adjustments made to treatment plans based on patient progress, barriers, side effects, treatment adherence, or evolving clinical needs.
- Integration with other therapies. Coordination of digital CBT-I with other sleep medicine services and interventions.

Documentation of clinician involvement. When digital CBT-I is incorporated into an integrated treatment plan, documentation should clearly reflect the clinician's ongoing assessment, treatment planning, and management activities rather than merely noting that a patient is using a digital therapeutic.

Appealing Digital CBT-I Denials

When appealing denials for digital CBT-I services, practices should focus on demonstrating that the intervention was medically necessary, evidence-based, and selected to address a diagnosed sleep disorder using established treatment principles.

Appeal documentation should include:

- **Clinical rationale for treatment selection.** Explain why digital CBT-I was chosen and how it addresses the patient's diagnosed sleep disorder and treatment needs.
- **Evidence supporting CBT-I effectiveness.** Include references to clinical practice guidelines, peer-reviewed literature, and evidence supporting CBT-I as a first-line treatment for chronic insomnia.
- **Documentation of clinician involvement.** Describe treatment oversight, patient monitoring, interpretation of clinical information, treatment recommendations, and modifications to the care plan.
- **Patient-specific barriers to alternative treatment options.** Document obstacles such as lack of access to trained behavioral sleep medicine clinicians, geographic limitations, transportation challenges, scheduling barriers, long wait times, or other factors supporting use of digital treatment.
- **Clinical outcomes and treatment response.** Include evidence of symptom improvement, adherence, functional improvement, or progress toward treatment goals when available.
- **Medical necessity and diagnosis documentation.** Demonstrate that the intervention was used to treat a diagnosed sleep disorder associated with clinically significant symptoms and functional impairment.

Best Practice: When implementing digital CBT-I, practices should establish standardized workflows for patient selection, coverage verification, documentation, progress monitoring, and appeals management. Thorough documentation of clinician involvement and medical necessity may help strengthen reimbursement and appeal success when coverage determinations are challenged.

X. Appeals: Template Letters

Sample Appeal Language for CBT-I and Insomnia Treatment Denials: Medical Necessity

[Clinician Name, Credentials]
[Practice Name]
[Address]
[City, State ZIP]
[Phone Number]
[Fax Number]
[Email Address]

[Date]

Claims Review Department
[Insurance Company Name]
[Address]
[City, State ZIP]

RE: Appeal of Claim Denial – Medical Necessity
Patient Name: **[Patient Name]**
Member ID: **[Member ID]**
Date(s) of Service: **[Date(s) of Service]**
Claim Number: **[Claim Number]**
Provider NPI: **[NPI Number]**

Dear Claims Review Department:

I am writing to formally appeal the denial of coverage for behavioral sleep medicine services provided to my patient, **[Patient Name]**, on **[Date(s) of Service]**. According to the Explanation of Benefits (EOB), the claim was denied on the basis that the services were not medically necessary.

I respectfully request reconsideration of this determination. The clinical documentation submitted with this appeal demonstrates that the services provided were medically necessary, evidence-based, and appropriate for the diagnosis and treatment of the patient's condition.

The patient meets diagnostic criteria for chronic insomnia disorder and experiences clinically significant impairment in daytime functioning, including fatigue, impaired concentration, and reduced quality of life. These symptoms have adversely affected the patient's health and daily functioning and warrant clinical intervention.

Cognitive Behavioral Therapy for Insomnia (CBT-I) is widely recognized as the first-line treatment for chronic insomnia and has demonstrated effectiveness in improving sleep outcomes while reducing reliance on pharmacologic therapy. The services provided were consistent with established standards of care and were specifically directed toward addressing the patient's diagnosed sleep disorder and associated functional impairment.

The enclosed documentation supports the medical necessity of the services provided and includes:

- Clinical documentation supporting the diagnosis of chronic insomnia disorder
- Records describing the patient's symptoms and functional impairment
- Treatment plans and progress notes documenting the behavioral interventions provided
- Documentation demonstrating the patient's response to treatment and ongoing clinical needs
- Supporting literature and/or clinical practice guideline references, as applicable
- Given the patient's documented diagnosis, symptom severity, and functional impairment, the behavioral sleep medicine services furnished were both clinically appropriate and medically necessary. Denial of coverage is inconsistent with current evidence-based treatment recommendations for chronic insomnia.

Based on the information provided, I respectfully request that [Insurance Company Name] overturn the denial and provide reimbursement for the services rendered.

Thank you for your consideration of this appeal. If additional information is needed, please contact me at [**Phone Number**] or [**Email Address**].

Sincerely,

[**Clinician Name, Credentials**]
[**Title**]
[**Practice Name**]

Enclosures:

- Clinical notes
- Treatment plan
- Progress notes
- Supporting clinical literature/guidelines
- Additional documentation supporting medical necessity

Sample Appeal Language for CBT-I and Insomnia Treatment Denials: Non-Covered Service Denial

[Clinician's Name]
[Practice Name]
[Address]
[City, State, ZIP Code]
[Phone Number]
[Fax Number]
[Email Address]

[Date]

Claims Review Department
[Insurance Company Name]
[Address]
[City, State, ZIP Code]

RE: Appeal of Claim Denial – Non-Covered Service
Patient Name: **[Patient Name]**
Patient ID / Member #: **[Member ID]**
Date(s) of Service: **[Date(s) of Service]**
Claim Number: **[Claim Number]**
Provider NPI #: **[NPI Number]**

Dear Claims Review Department:

I am writing to formally appeal the denial of coverage for behavioral sleep medicine services provided to my patient, **[Patient Name]**, on **[Date(s) of Service]**. According to the Explanation of Benefits (EOB), the claim was denied because the services were classified as a non-covered benefit under the patient's health plan.

I respectfully request reconsideration of this determination. The denied services represent evidence-based treatment for a diagnosed sleep disorder and were provided to address a documented medical condition that significantly affects the patient's health, daytime functioning, and quality of life.

The patient has a diagnosed sleep disorder, including [insert diagnosis], which is associated with clinically significant symptoms and functional impairment. Untreated sleep disorders are known to adversely affect physical health, mental well-being, occupational functioning, safety, and quality of life. The services provided were specifically directed toward the assessment and treatment of the patient's sleep disorder and were furnished in accordance with generally accepted standards of care.

The treatment provided is consistent with established evidence-based approaches for managing sleep disorders and was selected based on the patient's clinical presentation, symptom severity, treatment history, and individualized care needs. The services were intended to improve sleep health, reduce symptom burden, enhance daytime functioning, and support long-term disease management.

The enclosed documentation demonstrates that the services were clinically appropriate and medically necessary for the treatment of a diagnosed medical condition. Documentation includes clinical records establishing the diagnosis, treatment plans, progress notes, and evidence supporting the therapeutic interventions provided.

Although the claim was denied as a non-covered service, the treatment rendered addresses a documented medical condition and reflects evidence-based care recognized within the field of sleep medicine. We respectfully request that the claim be re-reviewed in light of the enclosed clinical documentation and that coverage be provided for the services rendered.

Thank you for your time and consideration. If additional information is required, please contact me at [**Phone Number**] or [**Email Address**]. I appreciate your prompt review of this appeal and look forward to your reconsideration of this claim.

Sincerely,

[**Clinician's Full Name, Credentials**]
[**Title/Position**]
[**Practice Name**]

Enclosures:

- Clinical notes
- Treatment plan
- Progress notes
- Supporting documentation of diagnosis
- Documentation supporting medical necessity
- Relevant clinical literature or practice guidelines (if applicable)

Sample Appeal Language for CBT-I and Insomnia Treatment Denials: Health and Behavior Code Denial

[Clinician's Name]
[Practice Name]
[Address]
[City, State, ZIP Code]
[Phone Number]
[Fax Number]
[Email Address]

[Date]

Claims Review Department
[Insurance Company Name]
[Address]
[City, State, ZIP Code]

RE: Appeal of Claim Denial – Health and Behavior Assessment and Intervention (HBAI) Services
Patient Name: **[Patient Name]**
Patient ID / Member #: **[Member ID]**
Date(s) of Service: **[Date(s) of Service]**
Claim Number: **[Claim Number]**
Provider NPI #: **[NPI Number]**

Dear Claims Review Department:

I am writing to formally appeal the denial of coverage for Health and Behavior Assessment and Intervention (HBAI) services provided to my patient, **[Patient Name]**, on **[Date(s) of Service]**. According to the Explanation of Benefits (EOB), the claim was denied because the submitted code was considered non-covered, incorrect, or otherwise ineligible for reimbursement.

I respectfully request reconsideration of this determination. The submitted Health and Behavior Assessment and Intervention codes were selected because the services addressed behavioral factors affecting a diagnosed medical condition. The services were not psychotherapy services and were appropriately billed using the HBAI code set.

The patient has a diagnosed sleep disorder, including [insert diagnosis], which is associated with behavioral, cognitive, and lifestyle factors that affect disease management, symptom severity, treatment adherence, and clinical outcomes. The purpose of the services provided was to assess and address these factors in order to improve management of the patient's medical condition.

The interventions furnished focused on the relationship between behavior and health and were directed toward improving the patient's health status and treatment outcomes. Examples of interventions provided may include cognitive and behavioral strategies to improve sleep-related behaviors, treatment adherence, symptom management, and self-management of the diagnosed sleep disorder. These services were not provided for the treatment of a primary mental health condition and did not constitute psychotherapy.

The use of Health and Behavior Assessment and Intervention codes accurately reflects the nature of the services rendered. The coding selected was consistent with the clinical purpose of the encounter and appropriately describes

services addressing behavioral factors that influence a documented medical condition.

Supporting documentation is enclosed and demonstrates:

- The patient's diagnosed medical condition.
- The behavioral factors affecting the patient's health and treatment outcomes.
- The clinical rationale for the intervention provided.
- The specific services furnished during the encounter.
- The medical necessity and appropriateness of using HBAI services.

Based on the clinical documentation and the purpose of the services rendered, I respectfully request that [**Insurance Company Name**] reconsider this denial and provide reimbursement for the Health and Behavior Assessment and Intervention services provided.

Thank you for your time and consideration. If additional information is required, please contact me at [**Phone Number**] or [**Email Address**].

Sincerely,

[**Clinician's Full Name, Credentials**]
[**Title/Position**]
[**Practice Name**]

Enclosures:

- Clinical notes
- Assessment documentation
- Treatment plan
- Progress notes
- Documentation supporting medical necessity
- Additional supporting clinical documentation

Sample Appeal Language for CBT-I and Insomnia Treatment Denials: Telehealth Denial

[Clinician's Name]
[Practice Name]
[Address]
[City, State, ZIP Code]
[Phone Number]
[Fax Number]
[Email Address]

[Date]

Claims Review Department
[Insurance Company Name]
[Address]
[City, State, ZIP Code]

RE: Appeal of Claim Denial – Telehealth Services
Patient Name: **[Patient Name]**
Patient ID / Member #: **[Member ID]**
Date(s) of Service: **[Date(s) of Service]**
Claim Number: **[Claim Number]**
Provider NPI #: **[NPI Number]**

Dear Claims Review Department:

I am writing to formally appeal the denial of coverage for telehealth behavioral sleep medicine services provided to my patient, **[Patient Name]**, on **[Date(s) of Service].** According to the Explanation of Benefits (EOB), the claim was denied due to issues related to telehealth coverage, billing, or claim submission.

I respectfully request reconsideration of this determination. The services were delivered in compliance with the payer's telehealth requirements and were medically necessary for the evaluation and treatment of the patient's diagnosed sleep disorder.

The patient received behavioral sleep medicine services through telehealth to address **[insert diagnosis]**, a condition associated with clinically significant symptoms and impairment in health, functioning, and quality of life. The services provided were consistent with established standards of care and represented appropriate treatment for the patient's condition.

The services were delivered in compliance with the payer's telehealth requirements. Appropriate telehealth modifiers were submitted, patient consent was documented, and all clinical documentation requirements were satisfied. In addition, the services were rendered by a qualified provider acting within the scope of applicable licensure, credentialing, and payer participation requirements.

Documentation maintained in the patient's medical record supports:

- The patient's diagnosis and clinical need for treatment.
- Documentation of informed consent for telehealth services.
- The telehealth modality utilized during the encounter.
- The date, duration, and content of the services provided.
- Compliance with applicable telehealth billing and documentation requirements.
- The medical necessity of the services rendered.

The enclosed records demonstrate that the claim was billed appropriately and that all telehealth requirements were met at the time services were provided. Based on the supporting documentation and compliance with payer telehealth policies, we respectfully request reprocessing of the claim and reimbursement for the services rendered.

Thank you for your consideration of this appeal. If additional information is needed, please contact me at [**Phone Number**] or [**Email Address**]. We appreciate your prompt review and reconsideration of this claim.

Sincerely,

[**Clinician's Full Name, Credentials**]
[**Title/Position**]
[**Practice Name**]

Enclosures:

- Clinical notes
- Telehealth encounter documentation
- Documentation of patient consent
- Treatment plan
- Progress notes
- Supporting documentation of medical necessity
- Additional documentation supporting telehealth compliance

Sample Appeal Language for CBT-I and Insomnia Treatment Denials: Digital CBT-I Coverage

[**Clinician's Name**]
[**Practice Name**]
[**Address**]
[**City, State, ZIP Code**]
[**Phone Number**]
[**Fax Number**]
[**Email Address**]

[**Date**]

Claims Review Department
[**Insurance Company Name**]
[**Address**]
[**City, State, ZIP Code**]

RE: Appeal of Claim Denial – Digital Cognitive Behavioral Therapy for Insomnia (Digital CBT-I)
Patient Name: [**Patient Name**]
Patient ID / Member #: [**Member ID**]
Date(s) of Service: [**Date(s) of Service**]
Claim Number: [**Claim Number**]
Provider NPI #: [**NPI Number**]

Dear Claims Review Department:

I am writing to formally appeal the denial of coverage for digital Cognitive Behavioral Therapy for Insomnia (digital CBT-I) services provided to my patient, [**Patient Name**]. According to the Explanation of Benefits (EOB), the claim was denied on the basis that the service was considered non-covered, investigational, experimental, or otherwise ineligible for reimbursement.

I respectfully request reconsideration of this determination.

The patient has a diagnosis of **chronic insomnia disorder**, a condition associated with significant impairment in sleep quality, daytime functioning, overall health, and quality of life. The treatment provided was selected to address the patient's documented sleep disorder and was consistent with current evidence-based standards of care.

Digital CBT-I programs have emerged as an important treatment option for patients who lack access to trained behavioral sleep medicine clinicians. Limited access to qualified behavioral sleep medicine providers remains a significant barrier to treatment for many patients. Digital delivery platforms help expand access to evidence-based insomnia treatment while providing structured therapeutic interventions based on established CBT-I principles.

Importantly, digital CBT-I is not an investigational intervention. The therapeutic components of digital CBT-I are derived from Cognitive Behavioral Therapy for Insomnia, which is widely recognized as the first-line treatment for chronic insomnia. Multiple clinical practice guidelines have recommended CBT-I as the preferred initial treatment for chronic insomnia due to its demonstrated efficacy, durability of benefit, and favorable safety profile compared with long-term pharmacologic management.

In addition, published peer-reviewed medical literature has demonstrated that digital CBT-I can improve insomnia symptoms, sleep quality, sleep efficiency, and daytime functioning in patients with chronic insomnia. Research has also shown that digital CBT-I may increase treatment accessibility and help address workforce shortages in behavioral sleep medicine by extending evidence-based care to patients who may not otherwise have access to trained CBT-I clinicians.

The digital CBT-I program utilized for this patient was prescribed and/or recommended as part of a comprehensive treatment plan for a diagnosed medical condition. The intervention was clinically appropriate based on the patient's diagnosis, symptoms, treatment needs, and access considerations. The services were intended to improve sleep outcomes, reduce symptom burden, enhance daytime functioning, and support long-term management of the patient's sleep disorder.

The enclosed documentation supports:

- The patient's diagnosis of chronic insomnia disorder.
- The patient's clinical symptoms and functional impairment.
- The medical necessity of treatment.
- The clinical rationale for selecting digital CBT-I.
- The evidence-based nature of the intervention.
- Treatment monitoring, participation, and clinical outcomes, when applicable.

Given the substantial body of clinical evidence supporting CBT-I and the growing evidence demonstrating the effectiveness of digital CBT-I delivery models, we respectfully request that [**Insurance Company Name**] reconsider this denial and provide coverage for the services rendered.

Thank you for your time and consideration. If additional information is required, please contact me at [**Phone Number**] or [**Email Address**]. We appreciate your prompt review of this appeal.

Sincerely,

[**Clinician's Full Name, Credentials**]
[**Title/Position**]
[**Practice Name**]

Enclosures

- Clinical notes
- Treatment plan
- Documentation supporting diagnosis and medical necessity
- Progress notes
- Documentation regarding digital CBT-I utilization and outcomes
- Relevant clinical practice guidelines
- Published literature supporting digital CBT-I effectiveness

References

1. **Buysse, D., Arnedt, J.T., Buenaver, L.** *et al.* **Combination treatment for chronic insomnia disorder in adults: an American Academy of Sleep Medicine clinical practice guideline.** *J Clin Sleep Med* **22, 56 (2026). https://doi.org/10.1007/s44470-025-00038-8.**

2. **Riemann D, Baglioni C, Bassetti C, et al. European guideline for the diagnosis and treatment of insomnia.** *J Sleep Res.* **2017;26(6):675-700.**

3. **Thorndike FP, Ritterband LM, Saylor DK, Magee JC, Gonder-Frederick LA, Morin CM. Validation of the Insomnia Severity Index as a web-based measure.** *Behav Sleep Med.* **2011;9(4):216-223.**

4. **Cheng P, Luik AI, Fellman-Couture C, et al. Efficacy of digital CBT-I interventions for insomnia: systematic review and meta-analysis.** (*Use the most current review available when finalizing the guide.*)

5. **AASM Clinical Practice Guideline and related AASM insomnia treatment resources supporting CBT-I as first-line therapy for chronic insomnia.**

XI. Medical Necessity Documentation Templates

Chronic Insomnia Disorder: Required Documentation Elements

Diagnosis:

Duration of Symptoms:

Sleep Complaints:

- ☐ Difficulty Initiating Sleep
- ☐ Difficulty Maintaining Sleep
- ☐ Early Morning Awakening
- ☐ Non-Restorative Sleep

Frequency:

Daytime Consequences:

- ☐ Fatigue
- ☐ Excessive Sleepiness
- ☐ Cognitive Impairment
- ☐ Mood Disturbance
- ☐ Occupational Impairment
- ☐ Reduced Quality of Life

Previous Treatments Attempted:

Clinical Rationale for CBT-I:

Treatment Goals:

Expected Outcomes:

PAP Adherence Behavioral Intervention: Required Documentation Elements

Diagnosis:

Current PAP Usage:

Adherence Barriers:

- ☐ Claustrophobia
- ☐ Anxiety
- ☐ Mask Intolerance
- ☐ Insomnia
- ☐ Pressure Intolerance
- ☐ Motivation Challenges

Behavioral Interventions Implemented:

- ☐ Desensitization
- ☐ Motivational Interviewing
- ☐ Stimulus Control
- ☐ Cognitive Restructuring
- ☐ Behavioral Coaching

Clinical Rationale:

Circadian Rhythm Sleep-Wake Disorders: Required Documentation Elements

Diagnosis:

Circadian Pattern:

Functional Impairment:

Behavioral Interventions:

- ☐ Chronotherapy
- ☐ Light Therapy Education
- ☐ Sleep Scheduling
- ☐ Behavioral Adherence Counseling

Clinical Goals:

Expected Outcomes:

Behavioral Sleep Medicine Reimbursement Quick Reference

Before submitting claims:

- ✓ Verify benefits
- ✓ Verify network participation
- ✓ Confirm prior authorization requirements
- ✓ Select appropriate CPT coding pathway
- ✓ Document medical necessity
- ✓ Document functional impairment
- ✓ Document evidence-based interventions
- ✓ Confirm telehealth requirements
- ✓ Track payer-specific behavioral health policies
- ✓ Maintain supporting documentation for appeals

Proper documentation, proactive verification, and familiarity with payer requirements can significantly improve reimbursement success for behavioral sleep medicine services and reduce administrative burden associated with claim denials.

XII. Glossary of Behavioral Sleep Medicine Billing Terms

CBT-I

Cognitive Behavioral Therapy for Insomnia, the recommended first-line treatment for chronic insomnia.

Health and Behavior Codes

CPT codes used to address behavioral factors affecting physical health conditions.

Medical Necessity

Documentation demonstrating that treatment is reasonable and necessary for diagnosis or treatment.

Behavioral Health Carve-Out

An arrangement in which behavioral health services are administered separately from medical benefits.

Peer-to-Peer Review

A discussion between the treating clinician and payer medical reviewer regarding coverage determination.

AASM

American Academy *of*

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