AASM American Academy of SLEEP MEDICINE®



SLEEP PSYCHOLOGY

REIMBURSEMENT GUIDE

Introduction

Behavioral sleep medicine services, including cognitive behavioral therapy for insomnia (CBT-I), PAP adherence support, and other behavioral interventions, are increasingly recognized as first-line, evidence-based treatments for sleep disorders. The American Academy of Sleep Medicine clinical practice guidelines reinforce the central role of these interventions, particularly for chronic insomnia.

Despite strong clinical evidence, reimbursement for sleep psychologists remains inconsistent across payers. Variability is driven by three key factors:

- Whether services are classified under mental health vs. medical benefits
- Differences in payer recognition of CPT coding pathways
- Alignment (or misalignment) between diagnosis codes and billed services

This educational resource is designed to help sleep psychologists and interdisciplinary sleep practices understand how diagnosis code selection affects reimbursement when billing psychotherapy and Health & Behavior (H&B) CPT codes. Payer policies, particularly Medicare and large commercial insurers, often reimburse the *same CPT code differently* depending on the ICD-10 diagnosis reported. This guidance reflects current Medicare coverage articles, Local Coverage Determinations (LCDs), and commercial payer policies.

Why Diagnosis Coding Matters for Sleep Psychology

Sleep psychologists frequently provide evidence-based behavioral treatments such as cognitive behavioral therapy for insomnia (CBT-I), which is recognized as a first-line treatment for chronic insomnia. While psychotherapy CPT codes (90832–90837) and Health & Behavior CPT codes (96156–96171) are nationally defined and broadly covered, payers assess medical necessity primarily through the diagnosis code.

Key policy realities include:

- Medicare psychotherapy coverage is tied to mental and behavioral health diagnoses rather than physiologic sleep disorders alone.
- Insomnia diagnoses classified in ICD-10-CM Chapter F ("F" codes, e.g., F51.01 — Mental, Behavioral and Neurodevelopmental Disorders) are more consistently reimbursed with psychotherapy codes than insomnia diagnoses coded in ICD-10-CM Diseases of the Nervous System ("G" codes, e.g., G47.00).
- Insomnia diagnoses classified in Chapter F (Mental, Behavioral and Neurodevelopmental Disorders) are more consistently reimbursed with psychotherapy codes than insomnia diagnoses in Diseases of the Nervous System.
- Health & Behavior codes are covered for behavioral interventions addressing a medical condition, but they may not be billed with psychiatric (F-coded) diagnoses.

As a result, denials often occur not because CBT-I or behavioral treatment is inappropriate, but because the diagnosis code does not align with the payer's coverage framework.

Behavioral Sleep Medicine Reimbursement Workflow

Selecting the Right CPT Code Pathway and ICD-10 Diagnosis

START Patient presents for behavioral sleep medicine services

1 Is the primary reason for the visit a sleep disorder that will be treated with behavioral interventions?

Examples: Insomnia, OSA with adherence issues, circadian rhythm disorder, parasomnia, etc.

NO → Consider alternative coding based on primary diagnosis and treatment provided.

YES

2 Is a behavioral sleep medicine provider also seeing the patient and providing a significant, separately identifiable E/M service on the same day?

Requires documentation of medical evaluation and management separate from the behavioral intervention.

YES →

INTEGRATED CARE PATHWAY (E/M + PSYCHOTHERAPY)

CPT Codes:
99202–99215 (E/M service)
90833 / 90834 / 90838 (Psychotherapy add-on)

ICD-10 Diagnosis:
G47.x (e.g., G47.33, G47.00) ± **F51.x** (as applicable)

NO

3 Is the primary condition a medical sleep disorder (e.g., OSA, chronic insomnia, circadian rhythm disorder) where behavioral treatment is addressing the medical condition?

Behavioral intervention is expected to improve the sleep disorder or its management.

YES →

HEALTH & BEHAVIOR ASSESSMENT/INTERVENTION

CPT Codes: 96156 – 96168 (HBAI codes)

ICD-10 Diagnosis:
G47.x (primary sleep disorder diagnosis)
Examples: G47.00 Insomnia, G47.33 OSA

Best for: Aligns with medical benefit coverage
· Growing payer acceptance
· Ensure documentation links behavior to medical condition

NO

4 Is the payer more likely to cover this service under behavioral health benefits?

Consider patient's plan design, prior authorization requirements, and historical claim outcomes.

YES →

BEHAVIORAL HEALTH PATHWAY (PSYCHOTHERAPY)

CPT Codes:
90791 (intake evaluation)
90832 / 90834 / 90837 (therapy sessions)

ICD-10 Diagnosis:
F51.x (e.g., F51.01, F51.04)
Other appropriate F-codes as applicable

Best for: Most consistent reimbursement
· Widely accepted across commercial payers

NO / UNSURE

DEFAULT OPTION When unsure, default to the Psychotherapy Pathway (**90834/90837 + F51.x**) to minimize denial risk. Reassess coding strategy based on payer response and documentation.

DOCUMENTATION ESSENTIALS *(All Pathways)*

01	02	03	04	05
Link diagnosis to functional impairment and treatment need	Define treatment goals and patient-centered outcomes	Document length, content, and patient response	For E/M + Psychotherapy: Clearly separate and document both services	Follow payer guidelines and prior authorization requirements

PRACTICE TIP **Know your payer.** Review the specific medical policy and coverage criteria for each payer you work with, as policies for behavioral sleep medicine can vary widely.

KEY

- **Behavioral Health Pathway** (908xx)
- **Medical Model Pathway** (9615x–9616x)
- **Integrated Care Pathway** (992xx + 9083x)

DMHT DEVICE MANAGEMENT

G0553: first 20 minutes/month
G0554: each additional 20 minutes

QUICK GUIDE

Common Sleep Disorders
(ICD-10 – Medical Benefit)

G47.00	Insomnia
G47.33	OSA
G47.21	Circadian rhythm sleep-wake disorder
G47.61	Periodic limb movement disorder

F51.x Behavioral Sleep Disorders
(Behavioral Health Benefit)

F51.01	Primary insomnia
F51.04	Psychophysiologic insomnia
F51.05	Insomnia due to mental disorder

Use the most specific diagnosis that supports medical necessity and aligns with the payer's benefit structure.

COMMON DENIAL TRIGGERS

· Mismatched CPT and ICD-10 codes
· Non-specific diagnoses (e.g., G47.9)
· Lack of medical necessity
· Insufficient documentation of behavioral intervention
· Exceeding plan session limits

APPEAL WITH STRONG CLINICAL RATIONALE AND GUIDELINE SUPPORT.

Important reminders:

- Do **not** select a mental health diagnosis solely for billing reasons.
- Health & Behavior codes may **not** be billed with Chapter F diagnoses.

Digital Mental Health Treatment (DMHT) codes G0553 and G0554

When a sleep psychology practice incorporates an eligible digital mental health treatment device into a behavioral therapy plan, G0553 and G0554 may be relevant for monthly treatment management services tied to the patient's therapeutic use of that device. These codes are distinct from standard psychotherapy CPT codes and Health & Behavior codes; they should be used only when the reported service meets payer requirements for DMHT device use, review of patient/device information, and required patient or caregiver communication during the calendar month.

G0553 describes the first 20 minutes of monthly treatment management directly related to DMHT device use. G0554 is reported for each additional 20 minutes of monthly treatment management. Practices should verify the payer's current coverage policy, documentation expectations, device eligibility requirements, and same-day billing rules before reporting these codes. Because these are DMHT treatment management services rather than telehealth psychotherapy services, practices should confirm payer-specific place-of-service and modifier rules before claim submission.

Medicare vs. Commercial Payer Coverage Comparison

Topic	Medicare (Traditional FFS & MA)	Commercial Payers (BCBS, UHC, Aetna – general patterns)
Psychotherapy CPT codes (90832–90837)	Covered when paired with mental/ behavioral diagnoses; LCDs emphasize psychiatric conditions	Broadly covered; diagnosis must align with behavioral health benefit
Preferred insomnia diagnosis for psychotherapy	F51.01, F51.09 outperform G47 codes in practice	Similar preference for F51 codes over G47 codes
G47 insomnia codes with psychotherapy	Inconsistent coverage; higher denial risk	Variable; some plans deny without a behavioral diagnosis
Health & Behavior CPT codes (96156–96171)	Covered for behavioral management of medical conditions; no psychiatric dx allowed	Increasingly recognized, often with unit caps or prior authorization
CBT-I recognition	Recognized in policy articles; reimbursement depends on diagnosis alignment	Often acknowledged as evidence-based but still diagnosis-driven
Digital/online CBT-I	Category III codes; generally non-covered	Coverage highly variable; generally considered investigational
E/M + Psychotherapy	Allowed with proper documentation; audit risk if not separated	Covered; often higher reimbursement but plan-dependent
Telehealth	Expanded but subject to periodic renewal	Broad coverage for psychotherapy; HBAI less consistent
Prior Authorization	Limited but increasing in some MAC regions	Common for sleep services and behavioral interventions

Key Takeaways for Members

- Diagnosis selection is a primary driver of reimbursement, not the psychotherapy code alone.
- Many Medicare and commercial payer policies demonstrate more consistent reimbursement of psychotherapy services when supported by appropriately documented behavioral health diagnoses (such as F51 insomnia disorders) than when supported solely by neurologic sleep disorder diagnoses (G47 series).
- Providers report differing experiences with reimbursement for F51.01 (Primary insomnia) and F51.04 (Psychophysiologic insomnia).
    - Some payers may also reimburse when a clinically appropriate secondary diagnosis, such as F54 (Psychological and behavioral factors associated with disorders or diseases classified elsewhere) or an applicable anxiety-related diagnosis, is reported.
    - Secondary diagnoses should only be reported when clinically supported, documented, and relevant to the patient's condition and treatment, not solely to obtain reimbursement.
- Health & Behavior codes offer an important pathway when treating insomnia linked to medical conditions—without using psychiatric diagnoses.
- Pairing HBAI codes with mental health diagnoses often leads to denials as not medically necessary
- Providers should verify payer-specific rules regarding same-day reporting of psychotherapy, E/M, and HBAI services. When psychotherapy and E/M services are reported together, documentation must support that each service was significant and separately identifiable. HBAI services generally should not be reported on the same date as similar behavioral health services unless payer policy allows and documentation supports distinct services.
- Using non-specific diagnoses may not meet payer coverage criteria.
- Clear documentation detailing the link between behavioral interventions and medical conditions, as well as functional impairment and treatment goals, is essential for both Medicare and commercial payers.
- Diagnosis coding must reflect the provider's documented clinical assessment and medical decision making. Diagnoses should not be selected based only on anticipated reimbursement outcomes. Documentation should clearly support the reported insomnia subtype and any coexisting behavioral health conditions.

CPT–Diagnosis pairings most likely to succeed (summary table)

Clinical Scenario	CPT Codes	ICD-10 Codes Most Likely to Pay
CBT-I for chronic insomnia	90832–90837	F51.01, F51.09
CBT-I with anxiety/depression	90832–90837	F41.1, F32/F33 + insomnia
Insomnia secondary to medical condition	96156, 96158–59	G47.01 + underlying medical dx
Behavioral treatment without psych dx	H&B codes only	Medical dx only (no F codes)
Digital/remote CBT-I	Currently limited	Category III / payer-specific

Disclaimer

This resource is for educational purposes only. Coverage policies vary by payer and contract. Members should verify requirements with individual payers and ensure that all coding reflects the patient's clinical presentation and documentation.

