AASM American Academy of SLEEP MEDICINE®

2027

UNATTENDED SLEEP TESTING CODES

Coding Quick Reference Guide for Sleep Medicine Coding and Billing Teams

AT A GLANCE

Effective January 1, 2027, CPT codes 95800, 95801, and 95806 are deleted. Six new codes report unattended sleep testing by service component and study complexity. Select the complexity level using BOTH the clinically relevant channel count and parameter-category count. The lower supported level determines complexity.

OVERVIEW

WHO	Coders, billers, revenue-cycle staff, sleep practices, sleep centers, hospitals, IDTFs, testing companies, and physicians or other qualified health care professionals (QHPs) furnishing unattended sleep testing services.
WHAT	A six-code, component-based family that separately reports the technical service and professional interpretation and report, with each component stratified by low, moderate, or high complexity.
WHEN	Use for dates of service on or after January 1, 2027. Continue using the applicable 2026 code set for dates of service through December 31, 2026.
WHERE	Unattended sleep studies performed outside attended laboratory polysomnography workflows. Confirm payer coverage, place-of-service, enrollment, authorization, and billing rules before testing.
WHY	The revised structure reflects modern technologies, broader physiologic data, varying study complexity, and separate technical and professional work.

NEW CODE FAMILY

Complexity	Technical	Professional	Channels	Parameter categories
Low	**95843**	**95847**	3-4	3-5
Moderate	**95844**	**95848**	5-10	6-8
High	**95846**	**95849**	11 or more	9 or more

MOST IMPORTANT RULE

Determine the level supported by channels and the level supported by parameter categories separately. Report the LOWER level. Example: 6 channels = moderate, but 5 parameter categories = low. Report the low-complexity code(s): 95843 and/or 95847.

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WHICH ENTITY BILLS WHICH CODE?

- Technical codes 95843, 95844, 95846: report only when the billing entity furnishes set-up, data acquisition, and technical analysis.
- Professional codes 95847, 95848, 95849: report only when a physician or other QHP performs the interpretation and final report.
- If one entity furnishes both components, report the matching technical and professional codes. If separate entities furnish the components, each entity reports only its own code.
- Do not append modifier TC or 26 to these dedicated component codes. There is no single global unattended sleep testing code in the new family.

CODE SELECTION WORKFLOW

1 Confirm service	2 Count channels	3 Count categories	4 Apply level	5 Choose code
Unattended study and component furnished	Clinically relevant signals recorded and used	Distinct clinically relevant parameter categories	Assign channel and category levels separately	Use lower level; select technical and/or professional

WHAT COUNTS?

CHANNELS	PARAMETER CATEGORIES
A channel is a data-collection pathway that monitors and displays a physiologic signal during sleep. Count only channels that provide clinically relevant information for the disorder being evaluated. Examples: airflow, SpO2, pulse rate, position, movement tracking, mandibular movement, EEG, EOG, EMG, snore, photoplethysmography, heart-rate variability, respiratory effort, ECG, RIP flow, and peripheral arterial tonometry.	Group measures by the disorder or physiologic process they describe. Examples: sleep summary, sleep stages, oxygen summary, OSA respiratory indices, non-OSA respiratory indices, cardiac, movement, seizure, positional, arrhythmia, and CO2 indices. Multiple measures in one category count only once. AHI, RDI, REI, pAHI, and similar obstructive indices remain one category.

COUNTING GUARDRAILS

Do not count device capability alone. Do not count raw signals or outputs that are not clinically relevant. Do not count direct and derived measures of the same physiologic domain separately. Do not treat multiple calculations with different labels as separate categories when they describe the same process.

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CODING EXAMPLES

Scenario	Channels	Categories	Supported level	Report
Practice furnishes both components	4 (Low)	4 (Low)	Low	95843 + 95847
Split-service arrangement	7 (Moderate)	7 (Moderate)	Moderate	Technical entity: 95844 Interpreting entity: 95848
Counts do not match	11 (High)	8 (Moderate)	Moderate	95844 and/or 95848

SAME-STUDY MATCHING RULE

When both components are reported for the same study, the technical and professional codes should reflect the same complexity level because they use the same underlying channels and parameter categories. A billing split does not create a different complexity level.

DO NOT REPORT / HIGH-RISK ERRORS

- Using 95800, 95801, or 95806 for dates of service on or after January 1, 2027.
- Automatically mapping a device model or legacy code to a new code without reviewing the study data and report.
- Selecting a higher level because the device can collect more signals than were clinically relevant, reviewed, or reported.
- Counting AHI, RDI, REI, and similar obstructive indices as separate parameter categories.
- Counting direct and derived sleep measures of the same domain separately.
- Using the new codes for prescreening or consumer-grade sleep monitoring devices.
- Reporting the technical service when the entity did not furnish set-up, acquisition, and technical analysis, or reporting the professional service without a physician/QHP interpretation and report.

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DOCUMENTATION AND CLAIM-READINESS CHECKLIST

BEFORE THE TEST	STUDY / TECHNICAL RECORD	INTERPRETATION / CLAIM
• Order and diagnostic purpose • Signs, symptoms, and covered indication • Why unattended testing is appropriate • Payer coverage and prior authorization • Entity responsible for each component • Medical necessity supported by the record	• Date of service and device used • Clinically relevant channels recorded • Parameter categories generated • Recording time, adequacy, technical quality, and signal quality • Patient instruction, acquisition, scoring, and technical analysis • Technical limitations, artifact, or data loss recorded	• Physician or QHP review • Study adequacy and relevant events • Clinical correlation with history/ prior studies • Final signed interpretation and report • Matching complexity; diagnosis, POS, provider, and payer edits checked • Correct code selected based on documented complexity

PRE-BILL CODER CHECK

Date	☐ Is the date of service before or after January 1, 2027?
Service	☐ Was this an unattended sleep study, not attended PSG, prescreening, or consumer monitoring?
Component	☐ Which entity furnished the technical service? Which physician/QHP furnished interpretation and report?
Channels	☐ How many clinically relevant channels were actually recorded and used?
Categories	☐ How many distinct clinically relevant parameter categories were generated and reviewed?
Level	☐ What level does each count support, and what is the lower level?
Match	☐ If both components are billed, do the technical and professional codes match?
Support	☐ Does the order, technical record, and final report support the selected code and medical necessity?
Payer	☐ Have current payer coverage, authorization, coding edits, POS, and reimbursement rules been verified?

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IMPLEMENTATION ITEMS FOR CODING AND BILLING TEAMS

- Load 95843, 95844, 95846, 95847, 95848, and 95849 into the chargemaster and billing system; retire legacy codes for 2027 dates of service.
- Update fee schedules, payer crosswalks, claim edits, scrubber logic, superbills, order sets, and report templates.
- Build a device inventory showing clinically relevant channels and parameter categories, but require study-specific confirmation before code assignment.
- Train clinical, sleep technologist, coding, billing, contracting, and denial-management teams on component ownership and the lower-level rule.
- Monitor early 2027 claims by payer, code, diagnosis, denial reason, authorization status, and payment variance; audit a sample of records for documentation support.

PAYER AND COMPLIANCE NOTE

CPT code selection does not guarantee coverage or payment. Coverage indications, prior authorization, permitted providers, place of service, frequency limits, diagnosis requirements, and claim-processing rules may vary by Medicare, Medicaid, and commercial payer. Use the 2027 CPT Professional Edition and current payer policies as the controlling references.

KEY REFERENCES

- 2027 CPT Professional Edition: final descriptors, definitions, tables, and reporting instructions.

Educational resource only. This guide does not replace the CPT codebook, payer policy, legal advice, or individualized coding review.

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