



Helpful hints for filing

Actigraphy studies

Overview

The following information describes coverage and payment information regarding actigraphy studies. Coding, coverage, payment and documentation guidelines are listed on the following pages. This is to be used as a guide. For an item to be covered by Medicare, the following conditions apply: (1) item must be eligible for a defined Medicare benefit category; (2) item must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; and (3) item must meet all applicable Medicare statutory and regulatory requirements.¹ *Please contact your local Medicare contractor for specific instructions.*

General coverage guidelines

Actigraphy studies may be covered for the diagnosis and treatment of sleep disorders. The Centers for Medicare and Medicaid Services (CMS) has not issued any coverage guidelines for actigraphy. Coverage and reimbursement for actigraphy services will vary by payer.

Coding guidelines

Previously, actigraphy services were reported using a Category III CPT code, to report emerging services or procedures for which data is required to establish the need for a permanent code. Category III CPT code 0089T (actigraphy testing, recording, analysis, and interpretation with a minimum of three-day recording) has been deleted and has been replaced by a new permanent Category I CPT code. Permanent Category I CPT codes are assigned to services or procedures that are consistent with contemporary clinical practice.

¹Section 1862 (a)1(A) of Title XVIII of the Social Security Act.

This information is for illustrative purposes only. You should not consider this to be either legal or reimbursement advice. Given the rapid and constant change in public and private reimbursement, Philips Healthcare cannot guarantee its comprehensiveness, accuracy, or timeliness. Philips urges you to seek your own counsel and experts for guidance related to reimbursement, including coverage, coding, and payment.

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As is the case with newly established codes, some payers may not recognize this code and provide instructions on alternate or potentially outdated coding guidelines. It will be important to submit claims using the newly established Category I CPT code 95803 for the reporting of actigraphy services. CPT 0089T should no longer be

reported. Additional codes that may be used to report actigraphy-related services are included in the chart below. It is recommended that healthcare providers verify recommended coding guidelines with payers prior to submitting claims for these services.

CPT code ²	Description
95803	Actigraphy, testing, recording, analysis, interpretation and report (minimum of 72-hours to 14 consecutive days of recording, requires the patient to wear a home monitor for 24-hours a day for 3 to 14 days).
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).
99090	Analysis of clinical data stored in computers (e.g., ECGs, blood pressure, hematologic data).
95999	Unlisted neurological or neuromuscular diagnostic procedures.

Billing for actigraphy services under Medicare Outpatient facilities

For 2009 under Medicare, CPT code 95803 is currently mapped to Ambulatory Payment Classification (APC) 0218. This APC has an associated allowable of \$78.30, with an unadjusted copayment as outlined in the table below.

CPT code ²	95803
APC	0218
2009 OPPs allowable ³	\$78.30
2009 Minimum unadjusted copayment	\$15.66

Physician office

If actigraphy services are provided in a physician office setting, the 2009 National Medicare Physician Fee Schedule indicates the code is subject to manual pricing.

CPT code ²	95803
Description	Actigraphy testing
Status code	C
Status code description	Carriers price the code
2009 MPFS allowable ⁴	\$0.00

Due to the status code for 95803, local Medicare contractors will establish relative value units (RVUs) and payment amounts for this service, generally on an individual case basis following the review of documentation (e.g., report). Physician offices will need to submit claims with a copy of a report for pricing purposes for the payer.

Use of modifiers

CPT code 95803 for reporting actigraphy has a professional and a technical component, allowing both facility and professional claims to be submitted. If billed by

a physician office, the physician office can bill the CPT code without a modifier, to represent a complete service or procedure which includes both the professional and technical components.

If professional services were only provided for the interpretation and report, these services could be reported by appending modifier -26 to the code (e.g., 95803 -26). In most cases, facilities will submit claims for the technical component of service and may need to append modifier -TC to 95803 (e.g., 95803 -TC).

Services and supplies

In addition to the actigraphy service itself, other ancillary services and supplies may be eligible for reimbursement. For example, if a patient is seen in the office to discuss the actigraphy record, an Evaluation & Management (E&M) code may be appropriate to report the patient encounter. If actigraphy is discussed in addition to other patient healthcare concerns, the extra time and complexity of the actigraphy discussion may allow for reporting of a higher level E&M code than would otherwise be billed. Also, healthcare providers may report replacement batteries and wrist bands provided to the patient for the actigraphy device, although these charges may not be covered by some payers such as Medicare.

The tables on the next page provide sample codes that may be appropriate to report for actigraphy services and supplies. These codes are generally used for the itemization of services. Many payers may consider supplies used to be included or bundled into the payment made for actigraphy.

² Current Procedural Terminology (CPT), Fourth Edition, 2009. American Medical Association, 2008. All rights reserved.

³ 2009 OPPS, Addendum B

⁴ 2009 MPFS, Addendum B, Non-Facility Allowable

Note: Inclusion or exclusion of a code does not imply any health insurance coverage or reimbursement policy.

CPT code ²	Description
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history, a detailed examination, and medical decision-making of low complexity.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.
99245	Office consultation for a new or established patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and straightforward medical-decision making.
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided).

In addition to CPT code 99070, some payers may require or prefer reporting of one or more of the following HCPCS level II codes for supplies:

HCPCS level II code	Description
A4556	Electrodes
A4557	Lead wires
A4558	Conductive gel
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
A9901	DME delivery, set up, and/or dispensing service component of another HCPCS code
A9999	Miscellaneous DME supply or accessory, not otherwise specified.

Documentation

Documentation or indication for testing and the parameters measured may be requested by a payer to demonstrate medical necessity for the service, such as a patient's sleep complaints and resulting daytime sleepiness, periodic leg movements, insomnia and nighttime arousal, phase shifting, or compliance follow-up. The following indications are examples of when actigraphy may be used to evaluate a patient's condition. Actual payer policy and coverage requirements should be verified prior to initiating actigraphy services for these or other conditions.

I. Insomnia or hypersomnia

Documentation of sleep/wake history is necessary for patients presenting with insomnia-like symptoms or hypersomnia in order to recommend treatment. Several days and nights of actigraphy recording indicate presence or absence of circadian rhythms disorders, poor sleep hygiene, daytime napping, frequent waking, and severity. Actigraphy may indicate that an overnight polysomnogram is not necessary.

II. Periodic leg movement

An actigraphy device used on a foot can identify the extent and frequency of periodic movement during sleep. Actigraphy monitoring may eliminate overnight polysomnography.

III. Daytime sleepiness complaints

Actigraphy identifies occurrences of daytime naps and nighttime sleep irregularities, and recognizes sleep related periodic body movements indicative of obstructive sleep apnea that may require follow-up polysomnography.

IV. Compliance of nasal CPAP treatment

Obstructive sleep apnea results in characteristic motions recognized by actigraphy. Continuous Positive Airway Pressure (CPAP) treatment helps eliminate these movements.

For more information from Philips Respironics concerning

Reimbursement	Customer service	Website
Information & fee schedules Educational materials & questions (coding, coverage and payment)	1-800-345-6443; listen to the instructions and follow prompts to select the insurance reimbursement information option	www.philips.com/respironics

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