


Oklahoma Health Care Authority  
Medical Professional Services  
Prior Authorization Guidelines

 8/1/14  
Medical Authorization Director Sig/Date

 1 Aug 2014  
Physician Medical Director Sig/Date

**SUBJECT: Sleep Studies**

The following CPT codes are reimbursed by OHCA for sleep study testing:

- ❖ **95805** – Multiple Sleep Latency testing (MSLT) or Maintenance of Wakefulness test (MWT)
- ❖ **95807** – Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate and oxygen saturation, attended by a technologist
- ❖ **95808** – Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
- ❖ **95810** – Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
- ❖ **95811** – Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist
- ❖ **95782** – Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
- ❖ **95783** – Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

In the Prior Approval process, please request only those codes you plan on using. For example, if you plan an all-night diagnostic followed the next night by a CPAP titration, for a member age 3 years, request 95782 and 95783 (one unit each). For example, if you plan a split-study for a 44 year old, request 95811 and one unit. If you are unsure of what code to order, please consult with your sleep center, a sleep specialist, or request assistance from the Health Care Authority.

**EFFECTIVE:** August 1, 2014

**OBJECTIVE:** To provide guidelines to assist in clinical decision making regarding medical necessity and consistency in the prior authorization (PA) process.

**DISCLAIMER:** This document is not a contract, and these guidelines do not reflect or represent every conceivable situation. Although all items contained in these guidelines may be met, this does not reflect, or imply, any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit. Prior Authorization is not a guarantee of member eligibility or SoonerCare payment.

**Description:** A number of sleep-related breathing disorders as well as some other medical conditions are known, that need various kinds of diagnostic tests to be done while the patient is asleep. These guidelines specify the conditions covered for “sleep studies” and delineate those conditions for which sleep studies are not covered. Parameters for approval of sleep studies for these covered conditions are outlined.

### **Definitions:**

**Abnormal Breathing Event:** The particular breathing activities measured in sleep studies. They are of four types:

1. **Snoring:** As in common usage, but noted here that not all snorers have a sleep related breathing disorder.
2. **Apnea:** Apnea is defined as a cessation of airflow for at least 10 seconds.
3. **Hypopnea:** Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.
4. **Respiratory Effort Related Arousals (RERA):** An increase in the level of consciousness or an awakening due to the increased effort of breathing.

**Apnea-Hypopnea Index (AHI):** AHI is equal to the number of episodes of apnea and hypopnea per hour of sleep and must be based on a minimum of 30 episodes recorded by polysomnography using actual recorded hours of sleep without symptoms and 10 episodes with symptoms

**Cataplexy:** The total or partial loss of muscle tone in response to sudden emotion.

**Epworth Scale:** This questionnaire consists of eight questions answered by a person using a 0 – 3 rating on each question. It assesses daytime sleepiness (in the person who normally sleeps at night). It asks the person to rate his or her probability of falling asleep under daily circumstances. The range of scores is 0 – 24. A score of 0 – 9 is considered within normal range, 10 – 24 indicates that expert medical advice should be pursued, and 16 and above indicates possibility of severe obstructive sleep apnea or narcolepsy.

**Interpreting physician** is defined by Oklahoma Statute as “a physician who provides professional interpretation of data generated by sleep diagnostic tests. An interpreting physician shall be board-certified in sleep medicine by the American Board of Sleep Medicine (ABSM) or the American Board of Medical Specialties or must have completed a one-year sleep medicine fellowship accredited by the Accreditation Council for Graduate Medical Education (ACGME) or received a Certification of Special Qualifications (CSQ) or

a Certification of Added Qualifications (CAQ) in Sleep Medicine issued by the American Osteopathic Association.”

**Maintenance of Wakefulness:** Same as Multiple Sleep Latency.

**Multiple Sleep Latency:** This test objectively measures the tendency to fall asleep, or the time it takes to fall asleep. It offers and measures 4 – 5 (usually) opportunities to nap for 20 minutes or so each. The test measures sleep-onset REM sleep, a parameter important in the diagnosis of narcolepsy. Interpretation requires a polysomnogram on the preceding night.

**Narcolepsy:** A syndrome that is characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep. The patient has inappropriate sleep episodes or attacks (e.g., while driving, in the middle of a meal, in the middle of a conversation), or continuous disabling drowsiness.

**Parasomnia:** Parasomnias are a group of conditions that represent undesirable or unpleasant occurrences during sleep. Behavior during these times can often lead to damage to the surroundings and injury to the patient or to others. Parasomnia may include conditions such as sleepwalking, sleep terrors, and rapid eye movement (REM) sleep behavior disorders.

**Polysomnogram (Polysomnography) (PSG):** Polysomnography is distinguished from sleep studies (see below) by the inclusion of sleep staging.

**Rapid Eye Motion (Sleep):** A stage of sleep occurring three to four times in a usual night of sleep where there are rapid and random eye movements, low muscle tone, and distinct changes on the EEG.

**Respiratory Disturbance Index (RDI):** RDI is defined as the number of apneas, hypopneas and respiratory effort related arousals (RERA) per hour of sleep time. When portable monitors, which do not measure sleep, are used then RDI is the total of apneas and hypopneas per hour of recording time. **Note:** in common usage, RDI is used interchangeably with AHI.

**Sleep Apnea:** This is a potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described (central, obstructive, and mixed). The nature of the apnea episodes can be documented by appropriate diagnostic testing. Ordinarily, a single polysomnogram can diagnose sleep apnea.

1. Obstructive apnea (OSA): Sleep apnea due to an occlusion of the airway.
2. Central sleep apnea: Sleep apnea due to an absence of respiratory effort.
3. Mixed sleep apnea: Sleep apnea may be due to a combination of these factors.

**Sleep diagnostic testing facility (SDTF):** Oklahoma Statute defines a SDTF as “a building or place situated in a fixed location or a mobile entity that is used to conduct sleep diagnostic tests and includes sleep disorder centers and laboratories for sleep-related breathing disorders, but does not include a hospital that conducts sleep diagnostic tests for its patients, including sleep diagnostic tests performed under arrangements made by a hospital for its patients whereby the hospital exercises professional responsibility over the arranged services.”

**Sleep Related Breathing Disorders (SRBD):** Sleep diseases the diagnosis of which, is addressed by sleep studies. They are of four types:

1. **Obstructive Sleep Apnea Syndrome (OSA):** Along with Upper Airway Resistance Syndrome (UARS), is an increase in respiratory effort due to breathing against relative or absolute airway obstruction resulting in more negative intrathoracic pressure and decreased or absent air flow.
2. **Central Sleep Apnea Syndrome (CSA):** Recurrent apnea during sleep occurring in the absence of upper airway obstruction and due to lack of effort.

3. **Cheyne-Stokes Respiration (CSR):** Cyclic fluctuation in sleep breathing with periods of central apnea or hypopnea alternating with hyperpnea in a crescendo and decrescendo manner.
4. **Alveolar Hypoventilation Syndrome (AHS):** Hypoxemia with increased PaCO<sub>2</sub> (hypercapnia) due to inappropriate central hypoventilation not due exclusively to obstructive apneas and hypopneas.

**Sleep Study:** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep for 6 or more hours. It requires physician review, interpretation and report. The studies are used to diagnose a variety of sleep disorders and to evaluate a patient’s response to therapies such as continuous positive airway pressure (CPAP).

**Split night study** is an overnight polysomnogram in which the patient spends the first half of the night being monitored for sleep apnea. If the study shows severe enough disease to merit treatment with CPAP, the technologist will place the patient on CPAP and will adjust the pressure on the CPAP to treat the underlying sleep apnea. This approach may be an alternative to one full night of diagnostic polysomnography followed by a second night of titration as long as: 1) CPAP titration is carried out for more than 3 hours; and 2) polysomnography documents that CPAP eliminates or nearly eliminates the respiratory events during REM and NREM sleep.

**Supervising physician** is defined by Oklahoma Statute as “a physician responsible for the supervision of the sleep diagnostic testing performed, including, but not limited to, the quality of the testing performed, the proper operation and calibration of the equipment used to perform sleep diagnostic tests and the actions of non-physician personnel engaged in the performance of the sleep diagnostic testing. A supervising physician shall be board-certified in sleep medicine by the American Board of Sleep Medicine (ABSM) or the American Board of Medical Specialties or shall have completed a one-year sleep medicine fellowship accredited by the Accreditation Council for Graduate Medical Education (ACGME), or received a Certification of Special Qualifications (CSQ) or a Certification of Added Qualifications (CAQ) in Sleep Medicine issued by the American Osteopathic Association.”

**Upper Airway Resistance Syndrome (UARS):** Commonly used interchangeably with OSA.

**For assistance in evaluating PA documentation, a “Sleep Diagnostic Testing Facility”** is defined in Oklahoma Statute 63-7002.3.6 as:

1. a building or place situated in a fixed location or a mobile entity that is used to conduct sleep diagnostic tests, and
2. includes sleep disorder centers and laboratories for sleep-related breathing disorders,
3. but does not include a hospital that conducts sleep diagnostic tests for its patients, including sleep diagnostic tests performed under arrangements made by a hospital for its patients whereby the hospital exercises professional responsibility over the arranged services.

**For assistance in evaluating PA documentation, the requirements for the “Supervising Physician”** as stated in Oklahoma Statute 63-7002 are

1. a physician responsible for the supervision of the sleep diagnostic testing performed, including, but not limited to, the quality of the testing performed, the proper operation and calibration of the equipment used to perform sleep diagnostic tests and the actions of nonphysician personnel engaged in the performance of the sleep diagnostic testing.

2. shall be board-certified in sleep medicine by the
  - a. American Board of Sleep Medicine (ABSM) or
  - b. the American Board of Medical Specialties or
  - c. shall have completed a one-year sleep medicine fellowship accredited by the Accreditation Council for Graduate Medical Education (ACGME), or
  - d. received a Certification of Special Qualifications (CSQ) or a Certification of Added Qualifications (CAQ) in Sleep Medicine issued by the American Osteopathic Association.

**For assistance in evaluating PA documentation, Sleep Diagnostic Testing Facilities shall be fully or provisionally certified or accredited by**

1. the American Academy of Sleep Medicine (AASM), or
2. the Joint Commission, or
3. the Accreditation Commission for Healthcare (ACHC).

**For assistance in evaluating PA documentation, "Interpreting physician"**

1. Is a physician who provides professional interpretation of data generated by sleep diagnostic tests,
2. shall be board-certified in sleep medicine by
  - a. the American Board of Sleep Medicine (ABSM), or
  - b. the American Board of Medical Specialties, or
  - c. must have completed a one-year sleep medicine fellowship accredited by the Accreditation Council for Graduate Medical Education (ACGME), or
  - d. received a Certification of Special Qualifications (CSQ) or a Certification of Added Qualifications (CAQ) in Sleep Medicine issued by the American Osteopathic Association.

## **GUIDELINES FOR PRIOR AUTHORIZATION:**

The OHCA defines Medical Necessity as "Services provided within the scope of the Oklahoma Medicaid Program shall meet medical necessity criteria. Requests by medical services providers for services in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority shall serve as the final authority pertaining to all determinations of medical necessity. Medical necessity is established through consideration of the following standards: Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability; documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the client's need for the service; treatment of the client's condition, disease or injury must be based on reasonable and predictable health outcomes; services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the client, family, or medical provider; services must be delivered in the most cost-effective manner and most appropriate setting; and services must be appropriate for the client's age and health status and developed for the client to achieve, maintain or promote functional capacity. (OAC 317:30-3-1)

## **Compliance with state law:**

All providers submitting a PA request must be in compliance with state laws and must use a facility in compliance with state law (Attachment A). If an audit determines the provider was not in compliance with the required state laws, recoupment of funds may be pursued. Complete and current documentation must either be submitted with the PAR or be on file with the legal department of the Oklahoma Health Care Authority. State law requires:

1. Documentation that the "Supervising Physician", as defined in 63-7200.3.7 has the qualifications required in 63-7200.4.C1.
2. Documentation that the "Interpreting Physician", as defined in 63-7200.3.2 has the qualifications required in 63-7200.4.C3.
3. Documentation that the "Sleep Diagnostic Testing Facility" as defined in 63-7200.3.6 meets the certification or accreditation requirements of 63-7200.4.C2.

**Documentation requirements for all sleep studies:** In addition to specific documentation noted under indications below, the following documentation must be included with the PAR for any sleep study:

1. Documentation submitted in order to request services or substantiate previously provided emergent services must demonstrate through adequate objective medical records, evidence sufficient to justify the member's needs for the service in accordance with OAC 317: 30-3-1.
2. Sleep studies must be ordered by a Physician (MD or DO), Physician's Assistant, or Advanced Practice Nurse. The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. Every page of the PAR must be legible.
4. Records must document one or more of the below indications.
5. Face to face evaluation by the ordering practitioner, the "supervising physician" or the "interpreting physician" must clearly document the indications for the sleep study. The evaluation must include a thorough sleep history including positives and pertinent negatives for snoring, apneas, nocturnal choking or gasping, restlessness and excessive daytime sleepiness and other symptoms as appropriate. Physical exam must include assessment of the airway anatomy or a referral for assessment of airway anatomy to be completed before the sleep study. Medical conditions known to be associated with SRBDs such as obesity, hypertension, stroke, heart disease and congestive heart failure must be addressed. The face-to-face evaluation must be current within six months of the study.
6. Results of the Epworth Sleepiness Scale conducted during the evaluation for members 16 years of age and older.
7. Home sleep studies are not compensable.

## **INDICATIONS for the procedure with requirements:**

**Narcolepsy:** In addition to the above, the following must be met:

1. Polysomnography must be completed on the night prior to Multiple Sleep Latency Testing (MSLT) if MSLT is indicated.

2. Specific indications for MSLT (eg, hypersomnolence, cataplexy, sleep paralysis, hypnogogic hallucinations etc.) must be clearly documented to establish medical necessity for MSLT.
3. Documentation of results of HLA DQB1-0602 marker testing, **only if already available from another evaluation** (testing for this marker is not required).

**Sleep Apnea:**

1. A Prior authorization will allow a "split-night" study (initial diagnostic polysomnogram followed by CPAP titration during polysomnography on the same night), as an alternative to two consecutive nights of study. The following requirements should be anticipated for a split night study:
  - a. pre-study evaluation documents the member has a high pretest probability of severe OSA since it is less reliable in patient with OSA of lesser severity, **and**
  - b. severe and unambiguous obstructive sleep apnea (AHI >40) during first 2 hours of sleep, **or**
  - c. significant suspicion of OSA documented in pre-study evaluation with AHI >= 5 per hour **and**
  - d. CPAP titration is carried out for more than 3 hours following.
2. A split study beginning on a given date with the titration beginning after midnight on the subsequent date is one study and may not be billed as two consecutive studies.
3. Should a split study be initiated and the required sleep time and titration time not be achievable, a following CPAP titration study will be authorized.

**Parasomnia:** In addition to the above, the following must be met:

1. Documentation that the condition is severe enough to interfere with the patient's well-being, or to interfere with the well-being of others should be clearly stated (ie the parasomnia is a danger to self or others).
2. Suspected seizure disorders as possible cause of the parasomnia must be ruled out with sleep EEG or other means and polysomnograms will not be approved for evaluation of suspected seizure disorders.

**The following are NOT covered** in the absence of evidence for another covered indication:

- a. Evaluation of chronic insomnia;
- b. Preoperative evaluation for laser-assisted uvulopalatopharyngoplasty without evidence of obstructive sleep apnea;
- c. To diagnose chronic lung disease without sign/symptoms suggestive of obstructive sleep apnea;
- d. For patients with seizure disorders who have no specific complaints consistent with a sleep disorder;
- e. In cases of typical, uncomplicated and non-injurious parasomnias;
- f. In cases of parasomnias when the diagnosis is clearly delineated by clinical evaluation;
- g. For patients with symptoms suggestive of periodic limb movement disorder or restless leg syndrome unless symptoms are suspected of being related to a covered indication;
- h. For the diagnosis of insomnia related to depression;

- i. For the diagnosis of circadian rhythm sleep disorders (i.e., rapid time-zone change [jet lag], shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non-24 hour sleep/wake disorder);
- j. Evaluation solely for the purpose of determining oxygen need in children or adults;
- k. Evaluation of impotence;
- l. Evaluation of migraine headaches;
- m. Apnea of prematurity.

**Children: Additional indications for children (18 years old and younger):**

1. Preoperative evaluation for adenotonsillectomy in children with SRBD if any of the following are documented:
  - a. Obesity
  - b. Down's Syndrome
  - c. Craniofacial abnormalities that interfere with the airway
  - d. Neuromuscular disorders affecting breathing
  - e. Sickle Cell Disease
  - f. Mucopolysaccharidoses
2. Preoperative evaluation for adenotonsillectomy without the above comorbidities where need for surgery is uncertain or with discordance between tonsillar size and reported severity of SRBD.
3. Clinical evaluation of the child suggests the diagnosis of Obstructive Sleep Apnea.
4. Postoperative evaluation after adenotonsillectomy if symptoms of SRBD persist
5. Postoperative evaluation after adenotonsillectomy in children with preoperative evidence for moderate to severe OSA or an indication from 1 above.
6. Determination of appropriate therapy (CPAP, BIPAP, etc.) in diagnosed OSA or other SRBD.
7. CPAP titration for diagnosed OSA
8. Clinical assessment suggests the diagnosis of congenital central alveolar hypoventilation syndrome or sleep related hypoventilation due to neuromuscular disorders or chest wall deformities.
9. Children on chronic CPAP to determine changing requirements due to growth and development.

**INDICATIONS for repeat testing:**

Repeat polysomnography or sleep testing requires persuasive documentation justifying the medical necessity for the repeated test. Repeat polysomnography/sleep testing may be indicated:

- a) if the subject could not sleep or slept for an insufficient amount of time to allow a clinical diagnosis;
- b) if the results were inconclusive or ambiguous; or
- c) if initiation of therapy or confirmation of the efficacy of prescribed therapy is needed.

**INDICATIONS for follow-up testing for members prescribed CPAP/BiPAP:**

1. Follow-up polysomnography or sleep studies are not routinely indicated for patients treated with CPAP whose symptoms continue to be resolved with CPAP treatment. With appropriate documentation, follow-up polysomnography studies may be indicated, however, for the following conditions:



- a. After substantial weight loss has occurred in patients on CPAP for treatment of sleep-related breathing disorders to ascertain whether CPAP is still needed, or is needed at the previously titrated pressure; or
  - b. After substantial weight gain has occurred in patients previously treated with CPAP successfully, who are again symptomatic despite the continued use of CPAP, to ascertain whether pressure adjustments are needed; or
  - c. When clinical response is insufficient or when symptoms return despite a good initial response to treatment with CPAP.
2. A prior authorization will be required for any follow-up study.
  3. No more than two studies will be allowed per year.

**SOURCES:**

- 1) Clete A, Kushida, MD, PhD, et. al. Practice Parameters for the Indications for Polysomnography and Related Procedures: An Update for 2005. SLEEP, Vol.28, No.4, 2005.
- 2) Local Coverage Determination (LCD) for Outpatient Sleep Studies (L32711). 8/13/2012.
- 3) Oklahoma State Statute 63- 7200.1 - 7200.5
- 4) Oregon Health and Science University, Obstructive Sleep Apnea Diagnosis in Children and Adolescents, Executive Summary, December, 2011.
- 5) American Academy of Sleep Medicine< Practice Parameters for the Indications for Polysomnography and Related Procedures: An Update for 2005.
- 6) American Academy of Sleep Medicine, The AASM Manual for the Scoring of Sleep and Associated Events, Rules, Terminology, and Technical Specifications, Version 2.0.3, 2014

Authored by



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## **Attachment A: Oklahoma Sleep Diagnostic Testing Regulation Act**

### **§63-7200.1. Short title.**

This act shall be known and may be cited as the "Oklahoma Sleep Diagnostic Testing Regulation Act".

Added by Laws 2009, c. 360, § 1.

### **§63-7200.2. Legislative findings.**

The Oklahoma Legislature hereby finds that:

1. There is a growing need for sleep diagnostic testing in the diagnosis and treatment of sleep disorders;
2. Sleep diagnostic testing is being performed in Oklahoma; and
3. Oklahoma law does not provide sufficient regulation of sleep diagnostic testing to assure the protection of the public.

Therefore, there is a need to provide legislation to enable the appropriate entities to regulate persons performing sleep diagnostic testing on the citizens of this state.

Added by Laws 2009, c. 360, § 2.

### **§63-7200.3. Definitions.**

As used in the Oklahoma Sleep Diagnostic Testing Regulation Act:

1. "Advanced practice nurse" means a person licensed to practice as an advanced practice nurse by the Oklahoma Board of Nursing pursuant to the Oklahoma Nursing Practice Act;
2. "Interpreting physician" means a physician who provides professional interpretation of data generated by sleep diagnostic tests. An interpreting physician shall be board-certified in sleep medicine by the American Board of Sleep Medicine (ABSM) or the American Board of Medical Specialties or must have completed a one-year sleep medicine fellowship accredited by the Accreditation Council for Graduate Medical Education (ACGME) or received a Certification of Special Qualifications (CSQ) or a Certification of Added Qualifications (CAQ) in Sleep Medicine issued by the American Osteopathic Association;
3. "Physician" means a person licensed to practice:
  - a. allopathic medicine and surgery by the State Board of Medical Licensure and Supervision pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act, or
  - b. osteopathic medicine by the State Board of Osteopathic Examiners pursuant to the Oklahoma Osteopathic Medicine Act;

4. "Physician assistant" means a person licensed to practice as a physician assistant by the State Board of Medical Licensure and Supervision pursuant to the Physician Assistant Act;
5. "Sleep diagnostic test" means any technological recording procedure used for the diagnosis of sleep-related breathing disorders or other disorders of sleep;
6. "Sleep diagnostic testing facility" means a building or place situated in a fixed location or a mobile entity that is used to conduct sleep diagnostic tests and includes sleep disorder centers and laboratories for sleep-related breathing disorders, but does not include a hospital that conducts sleep diagnostic tests for its patients, including sleep diagnostic tests performed under arrangements made by a hospital for its patients whereby the hospital exercises professional responsibility over the arranged services; and
7. "Supervising physician" means a physician responsible for the supervision of the sleep diagnostic testing performed, including, but not limited to, the quality of the testing performed, the proper operation and calibration of the equipment used to perform sleep diagnostic tests and the actions of non-physician personnel engaged in the performance of the sleep diagnostic testing. A supervising physician shall be board-certified in sleep medicine by the American Board of Sleep Medicine (ABSM) or the American Board of Medical Specialties or shall have completed a one-year sleep medicine fellowship accredited by the Accreditation Council for Graduate Medical Education (ACGME), or received a Certification of Special Qualifications (CSQ) or a Certification of Added Qualifications (CAQ) in Sleep Medicine issued by the American Osteopathic Association.

Added by Laws 2009, c. 360, § 3. Amended by Laws 2010, c. 200, § 1, eff. Nov. 1, 2010.

**§63-7200.4. Ordering and furnishing sleep diagnostic tests - Facility standards.**

- A. Sleep diagnostic tests shall be ordered by a physician, physician assistant or advance practice nurse.
- B. Sleep diagnostic tests shall be furnished:
  1. By a sleep diagnostic testing facility;
  2. By, or under arrangements made by, a hospital for its patients whereby the hospital exercises professional responsibility over the arranged services; or
  3. In the patient's home.
- C. Sleep diagnostic testing facilities shall meet the following standards:
  1. Sleep diagnostic testing facilities shall be supervised by a supervising physician as defined by this act;
  2. On and after January 1, 2010, sleep diagnostic testing facilities shall be fully or provisionally certified or accredited by the American Academy of Sleep Medicine (AASM), the Joint Commission or the Accreditation Commission for Healthcare (ACHC), except that the full or provisional certification or accreditation by AASM, the Joint Commission, or ACHC shall not

be required until June 30, 2010, for any sleep diagnostic testing facility that has submitted a complete application for certification or accreditation to AASM, the Joint Commission and/or ACHC on or before December 31, 2009;

3. An interpreting physician shall interpret the data generated by all sleep diagnostic tests conducted at a sleep diagnostic testing facility; and
4. Non-physician personnel conducting sleep diagnostic tests shall perform their duties under the direction and supervision of the supervising physician.

D. Sleep diagnostic tests performed in the patient's home shall be conducted under the supervision of a supervising physician and interpreted by an interpreting physician.

Added by Laws 2009, c. 360, § 4.

**§63-7200.5. Violations - Enforcement - Promulgation of rules.**

- A. It shall be unlawful for any facility or person to perform sleep diagnostic tests without having first complied with this act or as may otherwise be allowed by applicable law.
- B. The State Department of Health is authorized to enforce the provisions of this act.
- C. The State Board of Health shall promulgate rules and enforcement measures as necessary to implement the provisions of the Oklahoma Sleep Diagnostic Testing Regulation Act.

Added by Laws 2009, c. 360, § 5. Amended by Laws 2010, c. 200, § 2, eff. Nov. 1, 2010.