



Kaiser Foundation Health Plan of Washington

Clinical Review Criteria Actigraphy Testing for the Evaluation of Sleep Disorders

NOTICE: Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) provide these Clinical Review Criteria for internal use by their members and health care providers. The Clinical Review Criteria only apply to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. Use of the Clinical Review Criteria or any Kaiser Permanente entity name, logo, trade name, trademark, or service mark for marketing or publicity purposes, including on any website, or in any press release or promotional material, is strictly prohibited.

Kaiser Permanente Clinical Review Criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Kaiser Permanente reserves the exclusive right to modify, revoke, suspend or change any or all of these Clinical Review Criteria, at Kaiser Permanente's sole discretion, at any time, with or without notice. **Member contracts differ in health plan benefits. Always consult the patient's Evidence of Coverage or call Kaiser Permanente Member Services at 1-888-901-4636 (TTY 711), Monday through Friday, 8 a.m. to 5 p.m. to determine coverage for a specific medical service.**

Criteria For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	Polysomnography and Other Sleep Studies (L34040)
Local Coverage Article	Billing and Coding: Polysomnography and Other Sleep Studies (A57698) <i>(Actigraphy can be measured as part of a sleep test but will not be paid for separately)</i>

For Non-Medicare Members

Effective until September 1, 2024

There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.

Effective September 1, 2024

Refer to [Sleep Studies](#) criteria page

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

A sleep disorder (somnipathy) is a medical disorder of the sleep patterns. The international classification of sleep disorders (ICSD)-2 lists over 80 sleep disorders under eight major categories including insomnia, sleep-related breathing disorders, hypersomnia, circadian rhythm sleep disorders, parasomnia, sleep-related movement disorders, and others. It is estimated that 30-40% of Americans have a sleep complaint at any one time and that 10-15% suffer from chronic insomnia (Quan 2006).

The proper diagnosis and management of patients with sleep disorders depends on an accurate clinical history. There is a variety of sleep history questionnaires including the Epworth Sleepiness Scale (ESS) and the Pittsburgh Sleep Quality Index (PSQI). Keeping a sleep-wake diary is a standard procedure used for the subjective assessment of sleep and may give a more complete picture of the individual's sleep patterns and variability from day to day. Sleep diaries are useful for evaluating sleep over extended periods of time in the patient's home environment; they represent an important clinical tool and are often used in behavioral treatment of sleep disorders such as insomnia. However, self-documentation of sleep frequency and duration is prone to bias. The fully attended traditional polysomnography (PSG) is the basic diagnostic procedure and is considered the standard for evaluating sleep disorders. It is an overnight test performed in a sleep laboratory and comprises continuous recording of several

physiological variables including airflow, chest/abdominal movements, arterial oxygen saturation, electroencephalography (EEG), electrocardiogram [ECG], electromyography (EMG), and electrooculography (to measure eye movement). The EEG activity, eye movements, and muscle tone reveal the differences between wakefulness and sleep. Some investigators indicate that while the full PSG is widely considered the standard in clinical practice, it is not a true gold standard as it had not been validated. The use of PSG is limited by its high cost, time consumption, complexity, and considerable utilization of hospital resources. It may be impractical in some cases among whom sleep patterns must be assessed over extended periods of time. Moreover, PSG assesses sleep in an abnormal environment, which can alter its structure. These disadvantages of PSG have led to the search for alternative tools to diagnose and/or monitor sleep disorders in a natural environment (Bar 2003, Buysse 2005 Broughton 1996, Zou 2006, To 2009, Sunwoo 2010, Martin 2011).

Actigraphs, also called actometers or actimeters, were first used to record sleep and wakefulness based on movement in the early 1970s. The term actigraphy refers to methods utilizing miniaturized sensors that translate physical motion into a numeric presentation. Actigraphy simply measures movement, and is one dimensional, whereas polysomnography comprises at least three distinct types of data (EEG, EOG, and EMG), which jointly determine if a patient is asleep or awake. The actigraphy device may be placed on the wrist, ankle, or trunk. The best placement site for the actigraph to obtain the most reliable data is still controversial. In most studies it is worn on the nondominant wrist based on observations that wrist may detect more movements compared with the ankle and trunk, and that placement on the dominant arm detects more movement than the nondominant arm. The actigraphy device includes a small accelerometer that monitors and records the occurrence and degree of motion. It can collect data continuously over an extended period of one week or longer. Actigraphic data can be displayed and scored manually or downloaded to a computer for display and analysis by software and algorithms that give estimates of sleep-wake and circadian rhythm parameters. The collected data are translated into epochs (typically 30 seconds or 1 minute) of activity. Using validated algorithms, the epochs are scored as sleep or awake. The device interprets the presence of movement as time awake, and absence of movement as sleep time. Some investigators treat PSG and actigraphy measures as equally valid or alternative measures that provide an estimation of the time an individual spends sleeping and awake. However, actigraphy only measures movement; and electrographic sleep-wake status and motor activity/inactivity are not equivalent. Despite the sophisticated algorithms for actigraphy that may potentially estimate the time an individual spent sleeping and awake based on movement, actigraphy just provides an indirect estimate of sleep-wake as it is commonly defined (Broughton 1996, Lotjonen 2003, Ancoli 2003, Flemons 2003, Kuna 2010, Sanchez-Ortuno 2010, Calogiuri 2013).

Actigraphs vary widely in sizes and features and can be expanded to include sensors which monitor light, sound, temperature, and parkinsonian tremors. Some devices are programmable and allow the selection of specific modes of operation while others have only one fixed mode. New devices, scoring algorithms and operating procedures are continuously being developed and updated. Newer devices have the advantage of the small size and light weight making them more convenient for all patients. Different devices have different measuring mechanisms and scoring algorithms, but their results are usually interpreted equally between studies, despite the fact that research found that their accuracy in estimating sleep varies between population groups and from one device to the other (Broughton 1996, Lotjonen 2003, Ancoli 2003, Flemons 2003, Kuna 2010, Meltzer 2012, Blackwell 2011).

Actigraphy was reviewed by MTAC in 2007 and 2011 for detecting obstructive sleep apnea (OSA), and in 2008 for the assessment of sleep disorders, and did not meet the Committee's evaluation criteria. The technology is being re-reviewed for its use for the evaluation of insomnia and circadian rhythm disorders.

Medical Technology Assessment Committee (MTAC)

Actigraphy in the Treatment of Sleep Disorders

12/03/2007: MTAC REVIEW

Evidence Conclusion: The studies that evaluated the use of actigraphy for the assessment of sleep apnea did not use the technology alone but embedded/ or combined it with other devices as peripheral arterial tonometers (PAT), or respiratory polygraphs. Watch-PAT 100 was the device most commonly used in the published studies. The actometer estimated the total sleep time while the tests of respiratory function were used to calculate the apnea severity, and apnea hypopnea index (AHI). To date, there are no published controlled trials that would determine whether actigraphy can replace PSG or provide incremental information that would impact patient management decisions or improve health outcomes.

The population sizes of the studies varied from <20 patients to just over 200, and the majority assessed the portable monitors simultaneously with PSG in sleeping laboratories in the presence of sleep clinicians, and not in unattended settings. This would be ideal for testing the ability of the monitors to work but does not assess its performance in the patient's home where it is intended, which in turn may limit extrapolation of the results.

Moreover, the studies mainly included patients referred to sleep laboratories for suspected OSA. The high prevalence of the disorder among these patients would affect the sensitivity, specificity and likelihood ratios of the test that would also limit generalization of the results.

Diagnostic accuracy: Different algorithms were used for the evaluation of data. The investigators examined multiple respiratory disturbance index (RDI) thresholds for determining abnormal apnea hypopnea index (AHI) and define a positive result. The cutoff for used for AHI was arbitrary and varied between studies. Some investigators question the use of AHI as the correct reference standard. The Watch-PAT does not measure airflow and thus cannot differentiate hypopneas from apneas. Overall the results of the studies show that using PSG as the gold standards, the sensitivity of actigraphs embedded in peripheral arterial tonometers ranged from 82-90%, and specificity ranged from 68-90% depending on severity of the obstructive sleep apnea. The sensitivity tended to be lower, and specificity higher with increasing severity the disorder. The area under the curve (AUC) also varied between studies with severity of sleep apnea, and its measures. It ranged from 0.82 for patients with RDI.>10 in Bar's study, to 0.98 for AHI >30 in Garcia-Diaz study. This latter study also compared the respiratory polygraph (RP) performed in the hospital versus that at home, either with or without the addition of actigraphy. Its results showed that RP performed at the laboratory was more accurate than that done at home, and that the addition of actigraphy did not result in significant improvement but tended to overestimate sleep time. The agreement rate between actigraphy devices and PSG was reported in some studies and ranged from 80% to 93%, also depending on the severity of the obstructive sleep apnea.

Diagnostic impact: There is insufficient evidence to determine that actigraphy can provide information that may influence the management decisions for patients diagnosed with obstructive sleep apnea. **Therapeutic impact:** There is insufficient evidence to determine that using actigraphy for the diagnosis of obstructive sleep apnea would improve health outcomes.

Articles: The literature search revealed over 500 articles on actigraphy. The majority of the published studies used the technology to investigate patients with insomnia, circadian rhythm sleep disorders, and as an outcome measure to determine response of therapy, mainly melatonin 1. **Diagnostic accuracy** There were no randomized or nonrandomized trials that compared the results of actigraphy used alone, to polysomnography to determine if it can be used as an alternative to PSG in the diagnosis of obstructive sleep apnea. There were several studies that focused on the accuracy and usefulness of actigraphy in evaluating patients with obstructive sleep apnea. These studies, however, did not use actigraphs alone, but combined it with tests of respiratory function in order to calculate the apnea hypopnea index which measures the severity of apnea in these patients. The studies that compared the wrist worn devices with embedded actigraphs used PSG as the gold standard, and reported sensitivity, specificity, likelihood ratios or areas under the receiver operator curves were selected for critical appraisal. 2. **Diagnostic impact** the literature search did not reveal any study that would determine the influence of the technology on management decisions. 3. **Therapeutic impact** No studies on the impact of technology on patient outcomes were identified by the search. *The following studies were critically appraised:*

Ayas NT, Pittman S, MacDonald M, et al. Assessment of a wrist-worn device in the detection of obstructive sleep apnea. *Sleep Medicine* 2003;4:435-442 See [Evidence Table](#). Bar A, Pillar G, Dvir I, et al. Evaluation of a portable device based on peripheral arterial tone for unattended sleep studies. *Chest* 2003;123:695-703 See [Evidence Table](#). Garcia-Diaz E, Quintana-Gallego E, Ruiz A, et al. Respiratory polygraphy with actigraphy in the diagnosis of sleep apnea-hypopnea syndrome. *Chest* 2007; 131:725-732. See [Evidence Table](#). Hedner J, Pillar G, Pittman SD, et al. A novel adaptive wrist actigraphy algorithm for sleep-wake assessment in sleep apnea patients. *Sleep* 2004; 27:1560-1566. See [Evidence Table](#). Zou D, Grote L, Peker Y, et al. Validation a portable monitoring device for sleep apnea diagnosis in a population-based cohort using synchronized home polysomnography. *Sleep* 2006; 29:367-374. See [Evidence Table](#).

The use of actigraphy in the treatment of obstructive sleep apnea does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

02/04/2008: MTAC REVIEW

Actigraphy in the Treatment of Sleep Disorders

Evidence Conclusion: The published studies that evaluated actigraphy for the assessment of insomnia were conducted on selected groups of patients and used different actigraph models, software, and scoring algorithms. Most studies were conducted in sleep laboratories where recording conditions are standardized, and the artifacts controlled. These controls would be lost when the actigraphy devices are used in the home environment, where it is intended for use. Also, the algorithms that were validated for a specific model, mode of operation, or in a selected population may by not be equally accurate when used with a different brand of device, different gender or age group. The studies reviewed compared actigraphy to PSG, but the authors did not indicate whether the investigators interpreting the results of one test were blinded to the results of the other. The overall results of the studies reviewed, indicate that compared to polysomnography, actigraphy had a high sensitivity (92-98%) but very low specificity (28-48%) in detecting insomnia. It was also found to overestimate the total sleep time and sleep

efficiency. Actigraphy tends to overestimate sleep in people with insomnia when they are lying quietly as quiet wakefulness could be miscoded as sleep. Insomnia patients can remain inactive for a period of time attempting to fall asleep. On the other hand, actigraphy may underestimate the amount of sleep and overestimate the duration awake among those who are asleep but are restless or have large amounts of movements during sleep. The use of actigraphy for the assessment of periodic leg movements in sleep was evaluated in only a few small studies with methodological limitations. It was compared with polysomnography with bilateral anterior tibialis electromyography (BATEMG). However, EMG and leg actigraphy are not interchangeable, and each measures a different event. One records electrical activity of a certain muscle and the other records leg acceleration. Leg activity may be due to movement artifacts produced by obstructive sleep apnea. Kemlink et al (2007) did not exclude patients with suspicious sleep apnea and did not adjust for it in the analysis. In conclusion there is insufficient evidence to determine that actigraphy would replace PSG or add to its value in the diagnosis and management of patients with sleep disorders.

Articles: The following questions were considered in screening the published articles:

- 1) What is the diagnostic accuracy of actigraphy in the evaluation of patients with sleep disorders?
- 2) Does the use of actigraphy influence management decisions?
- 3) Does actigraphy lead to better treatment outcomes?

The literature search revealed over 500 articles on actigraphy. Due to the continuing development in the actigraphic devices, operating procedures, software, and scoring algorithms, the literature was screened to identify the more recent studies. Many of these used actigraphy to assess treatment effects or compared results from one actigraphy scoring algorithm to another. Others reported on the use of actigraphy in specific groups as very young infants, children with ADHD, patients with depression, dementia, Parkinson's disease, and others. There were a number of nonrandomized studies that compared actigraphy with other tools for the evaluation of patients with insomnia, periodic leg movement, narcolepsy and other medical disorders other than sleep disorders. The literature search did not reveal any study that would determine the influence of the technology on management decisions or its impact on patient outcome. *The following studies that compared actigraphy with the gold standard of polysomnography were critically appraised:* Kushida CA, Chang A, Gadkary C, et al. comparison of actigraphic, polysomnographic, and subjective assessment of sleep parameters in sleep-disordered patients. *Sleep Medicine* 2001;2:389-396. [See Evidence Table 3](#) and [see Evidence Table 4](#). Sivertsen B, Omvik S, Havik OE, et al. A comparison of actigraphy, polysomnography in older adults treated for chronic primary insomnia. *Sleep* 2006; 29:1353-1358. [See Evidence Table](#). Lichstein K, Stone KC, Donaldson J, et al. Actigraphy validation with insomnia. *Sleep* 2006; 29:232-239. [See Evidence Table](#). Kemlink D, Pretl M, Sonka K, et al. A comparison of polysomnographic and actigraphic evaluation of periodic limb movement in sleep. *Neurol Res* 2007; 000:1-5. [See Evidence Table](#). King MA, Jaffre MR, Morrish E, et al. The validation of a new actigraphy system for the measurement of periodic leg movement in sleep. *Sleep Medicine* 2005; 6:507-513. [See Evidence Table](#).

The use of actigraphy in the treatment of sleep disorders does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

02/04/2011

Actigraphy in the Treatment of Sleep Disorders

Evidence Conclusion: Accuracy of actigraphs/portable monitors for the detection of OSA. There were no published studies that compared portable monitors head-to-head. The accuracy of one device cannot be extrapolated to others even from the same class due to the differences in the number and types of signals recorded, sensors used, and the processing of signals. It is unknown which sensors or combinations have the highest sensitivity and specificity. Moreover, differences in scoring, testing environment, and night to night variability in the apnea hypopnea index (AHI) make generalization of results difficult. The studies that evaluated the use of actigraphy for the assessment of sleep apnea did not use the technology alone but embedded or combined it with other devices such as peripheral arterial tonometers (PAT), or respiratory polygraphs. Watch-PAT 100 was the device most commonly used in published studies. The actometer estimated the total sleep time while the tests of respiratory function were used to calculate the apnea severity, and apnea hypopnea index. As indicated in the 2007 review of the technology, the overall results of the studies reviewed showed that using PSG as the gold standards, the sensitivity of actigraphs embedded in peripheral arterial tonometers ranged from 82-90%, and specificity ranged from 68-90% depending on severity of the obstructive sleep apnea. The sensitivity tended to be lower, and specificity higher with increasing severity the disorder. The agreement rate between actigraphy devices and PSG was reported in some studies and ranged from 80% to 93%, also depending on the severity of the obstructive sleep apnea. Therapeutic impact of actigraphs/portable home monitors: In a randomized controlled trial that included 106 subjects with a high likelihood of OSA, Berry and colleagues (Evidence table 1) compared a clinical pathway with the watch-PAT 100 for the diagnosis and unattended autotitrating continuous positive airway pressure (CPAP) for those with an respiratory disturbance index (RDI) > 5 events /hour) to select an effective CPAP, versus standard in-laboratory PSG for diagnosis of OSA and CPAP

titration. Using a similar approach, Skomro and colleagues' trial (Evidence table 2) randomized 102 subjects with high a probability of OSA to either home-based diagnosis (using Embletta device that incorporates an actigraph) and auto-CPAP (APAP) or in-laboratory PSG. The in-home study was considered positive if the respiratory disturbance index (RDI) was > 5, and patients were offered auto-CPAP therapy for 1 week followed by fixed-pressure CPAP based on the auto-CPAP P95 results. An earlier trial (Mulgrew 2007) compared a type IV portable monitor and APAP titration to in-laboratory PSG in 68 patients (22% of the eligible population) with moderate to severe OSA and followed the patients for 3 months. All three trials showed no statistically significant differences in the Epworth Sleepiness Scale scores, quality of life scores, and other outcome studied between patients in the in-home diagnosis and auto CPAP titration group versus those in-laboratory PSG diagnosis and CPAP titration. These results however, should be interpreted with caution, and may not be generalized to the population at large due to several factors including but not limited to: participants in the studies were highly selected, had high pre-test probability of OSA, were mainly men, those with co-morbidities were excluded, short duration of follow-up, patients and/or providers were not blinded, and most of the participants in the PSG group had split-night PSG, which may lead to different outcomes of CPAP therapy than those derived from a full-night of CPAP titration. In addition, the studies were powered as superiority and not equivalence trials, and lack of significant differences does not necessarily indicate equivalence. Berry and colleagues powered their trial as noninferiority, but only for the compliance outcome. More high-quality randomized trials are needed to compare clinical outcomes of laboratory PSG versus home monitoring for sleep disorders among diverse population groups e.g. ethnic groups, women, the elderly, and patients with cardiopulmonary and neurological diseases as COPD, asthma, heart failure, neuromuscular diseases, and other sleep disorders.

Articles: The literature search revealed over 400 articles on actigraphy. The great majority were unrelated to the current review. The technology was frequently used to determine response of therapies for insomnia, mainly melatonin. There were few small validation studies on different portable monitor devices for diagnosing obstructive sleep apnea. There were no head-to-head comparisons between the devices for accuracy in detecting OSA. The search identified two published trials that compared the outcomes of in-laboratory diagnosis and treatment of OSA versus home-based diagnosis and treatment using portable monitoring devices that incorporated an actigraph. Both were critically appraised. Berry RB, Hill G, Thompson L, et al. Portable monitoring and autotitration versus polysomnography for the diagnosis and treatment of sleep apnea. *Sleep* 2008; 31:1423-1431. [See Evidence Table](#). Skormo RP, Gjevra J, Reid J, et al. Outcomes of home-based diagnosis and treatment of obstructive sleep apnea. *Chest* 2010; 138:257-263. [See Evidence Table](#).

The use of actigraphy in the treatment of sleep disorders does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

08/19/2013: MTAC REVIEW

Actigraphy in the Treatment of Sleep Disorders

Evidence Conclusion: The published studies that evaluated actigraphy for the assessment of insomnia as a primary outcome or in a secondary analysis were conducted on selected groups of patients and used different actigraph models, software, and scoring algorithms. The majority of sleep studies were conducted in sleep laboratories where the recording conditions are standardized, and the artifacts controlled. These controls would be lost when the actigraphy devices are used in the home environment, which is the primary intention for their use. In addition, the authors of the studies that compared actigraphy to PSG did not indicate whether interpretation of the results of one test was blinded to the results of the other. According to Sadeh (2011), a point that deserves attention is that actigraphic validation studies against PSG are all based on "time in bed" period whereas the main advantage of actigraphy is documenting sleep wake patterns continuously over 24-hour periods across days. Generalization of the results of the published studies may be limited to similar devices and population groups as the algorithms that were validated for a specific model, mode of operation, or in a selected population may not be equally accurate when used with a different brand of device, different gender, or age group. The results of the studies previously reviewed for MTAC showed that compared to polysomnography, actigraphy had a high sensitivity (92-98%) but very low specificity (28-48%) in detecting insomnia. These older as well as the more recent studies showed that actigraphy in general underestimates wake and overestimates the total sleep time and sleep efficiency. Individuals with insomnia can remain inactive for a period of time attempting to fall asleep, and actigraphy tends to overestimate sleep in these people as quiet wakefulness could be miscoded as sleep. On the other hand, actigraphy may underestimate the amount of sleep and overestimate the duration awake among those who are asleep but are restless or have large amounts of movements during sleep. A number of studies measured the correlation of actigraphy and PSG sleep outcomes as a measure of validity of actigraphy. These ranged between studies from 0.51-0.93 for total sleep time (TST), 0.48-0.85 for wake time after sleep onset (WASO), 0.36-0.81 for sleep efficiency (SE), and 0.30-0.95 for sleep onset latency (SOL). The MrOS Sleep Study (Blackwell et al, 2011), (Evidence Table 1) was embedded in the Osteoporotic Fractures in Men (MrOS) study and examined whether there was a difference between in-home-PSG and actigraphy (using the

Sleepwatch-O device) in estimating the total sleep time (TST). The authors used 3 modes for collecting actigraphic data to determine the one that corresponds highest with PSG. These modes were the proportional integration mode (PIM), time above threshold (TAT), and zero crossings mode (ZCM). PIM mode is a measure of the activity level or vigor of motion, the TAT mode measures time spent in motion or time spent in active state, and the ZCM measures the frequency of movement. The study had the advantage of including a large population size of community dwelling individuals and the use of in-home PSG as a gold standard. It however, only included men >60 years of age; and the PSG data were collected in 30-minute epochs while the actigraphy data were collected in 1-minute epochs with no synchronization in the clock time. This did not allow direct comparisons for each epoch. In addition, the authors did not explain whether the study participants were asked to complete sleep diaries. The results of the analysis showed that the three actigraphy modes either over-estimated or underestimated sleep and wake compared to PSG. The PIM mode of actigraphy corresponded more closely with PSG estimation of total sleep time (TST) than the TAT or ZCM modes, yet the correlation was weak to moderate. These results, however, may not be generalized to populations in different age groups or to other actigraphy devices. Van Den Berg and colleagues, 2008 (Evidence Table 2) measured the disagreement among actigraphy and sleep diary in estimating the total sleep time (TST) among 969 community dwelling elderly men and women participating in a cohort study that primarily investigated the incidence and risk factors of disabling disease. The participants in this sub study wore an actigraph (Actiwatch model AW4) and kept a sleep diary over a period of 5-7 consecutive days and nights. PSG was not used as the gold standard, but the authors only used the Actiwatch algorithm that was validated against polysomnography. The results of the analysis showed that, the estimated TST in the sleep diaries deviated more than one hour from that measured by actigraphy among 34% of the participants. The level of this disagreement decreased with subjective and actigraphic measures of sleep quality and increased with male gender, poor cognitive function, and functional disability. In a smaller study, Levenson and colleagues 2013 (Evidence Table 3) also compared the accuracy of actigraphy versus sleep diary among a group of older insomniac patients participating in a larger study that examined the effect of behavioral therapy on insomnia in older adults. The study included 119 participants with a mean age of 71.7 years (79 with insomnia confirmed with PSG, and 40 controls who did not undergo a PSG). The participants completed at least 7 nights of sleep diary and actigraphy (using the Minimitter Actiwatch). The results of the analyses indicate that the sleep diary parameters discriminated individuals with insomnia from good sleepers more accurately than actigraphy. The AUC of actigraphy was in the low to moderate range (0.58 for sleep efficiency, and 0.61 for total sleep time, the 95% CI contained the value of 0.5 for many of the parameters). Johnson and colleagues, 2007 (Evidence Table 4) examined the level of agreement between actigraphy and polysomnography among 181 adolescents 12-16 years of age. All participants completed an overnight PSG in a clinical research center. The week prior to the PSG and during the overnight PSG study, they wore a wrist actigraph (Octagonal Sleep watch 2.01) and completed daily sleep logs. Data were digitized in 1-minute epochs and the activity count was calculated and stored based on 1 of 3 data modes: PIM, TAT, and ZCM. The results of the analysis showed significant differences between the assessments of total sleep time by actigraphy vs. PSG. The differences were more pronounced for boys vs. girls and for those with sleep disturbed breathing. In conclusion there is insufficient evidence to determine that actigraphy would replace PSG or add to its value in the diagnosis and management of patients with insomnia or circadian rhythm disorders.

Articles: The literature search revealed over 800 articles published on actigraphy and sleep in the last 5 years. The great majority was unrelated to the current review; many reported on the use of actigraphy in specific groups as very young infants, children with ADHD, patients with depression, dementia, Parkinson's disease, and others. There was a lack of published studies on the use of actigraphy in patients with circadian rhythm sleep disorders. The studies that compared the use of actigraphy versus PSG for the evaluation of insomnia were mainly embedded in larger community-based studies conducted among specific age groups and for studying different conditions and/or factors that were not necessarily related to sleep. The following studies with more valid methodology, larger population size, and used actigraphy concurrently with PSG and /or sleep diary were selected for critical review. Blackwell T, Ancoli-Israel S, Redline S, Stone KL; Osteoporotic Fractures in Men (MrOS) Study Group. Factors that may influence the classification of sleep-wake by wrist actigraphy: the MrOS Sleep Study. *J Clin Sleep Med.* 2011;7:357-367 [See Evidence Table](#). Johnson NL, Kirchner HL, Rosen CL, et al. Sleep estimation using wrist actigraphy in adolescents with and without sleep disordered breathing: a comparison of three data modes. *Sleep.* 2007; 30:899-905. [See Evidence Table](#). Levenson JC, Troxel WM, Begley A, et al. A quantitative approach to distinguishing older adults with insomnia from good sleeper controls. *J Clin Sleep Med.* 2013; 9:125-131. [See Evidence Table](#). Van Den Berg JF, Van Rooij FJ, Vos H, et al. Disagreement between subjective and actigraphic measures of sleep duration in a population-based study of elderly persons. *J Sleep Res.* 2008; 17:295-302. [See Evidence Table](#).

The use of actigraphy in the evaluation of obstructive sleep apnea does not meet the *Kaiser Permanente Medical Technology Assessment Criteria*.

Applicable Codes

Considered Not Medically Necessary:

CPT® or HCPC Codes	Description
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

**To verify authorization requirements for a specific code by plan type, please use the [Pre-authorization Code Check](#).

CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Date Created	Date Reviewed	Date Last Revised
12/20/2007	12/07/2010 ^{MDCRPC} , 04/05/2011 ^{MDCRPC} , 10/04/2011 ^{MDCRPC} , 08/07/2012 ^{MDCRPC} , 06/04/2013 ^{MDCRPC} , 10/01/2013 ^{MPC} , 04/01/2014 ^{MPC} , 04/07/2015 ^{MPC} , 04/05/2016 ^{MPC} , 02/07/2017 ^{MPC} , 12/05/2017 ^{MPC} , 10/02/2018 ^{MPC} , 10/01/2019 ^{MPC} , 10/06/2020 ^{MPC} , 10/05/2021 ^{MPC} , 10/04/2022 ^{MPC} , 10/03/2023 ^{MPC} , 03/12/2024 ^{MPC}	02/07/2017

^{MDCRPC} Medical Director Clinical Review and Policy Committee

^{MPC} Medical Policy Committee

Revision History	Description of Change
04/01/2004	Criteria was retired
04/07/2015	Remove criteria from retired status. Medical necessity review will be effective July 5, 2015.
02/07/2017	Medicare is silent; MPC approved to adopt KAISER PERMANENTE criteria for Medicare members