

Clinical Policy: Multiple Sleep Latency Testing

Reference Number: CP.MP.24

Date of Last Revision: 04/22

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Description

Multiple Sleep Latency Testing (MSLT) objectively measures an individual's tendency to fall asleep and is a component of the routine evaluation for suspected narcolepsy or idiopathic hypersomnia. The MSLT is considered the standard measurement of sleepiness and has proven to be a sensitive and reproducible test for quantifying sleepiness; however, it is not a part of the routine evaluation for other sleep disorders. A polysomnogram (PSG) should be conducted on the night prior to the MSLT and should not demonstrate significant sleep pathology (e.g., obstructive sleep apnea, central sleep apnea, etc.) to ensure the most valid MSLT results.¹

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation[®] that MSLT is **medically necessary** for ages two years and above, when all of the following criteria are met:
 - A. Excessive daytime sleepiness (EDS) for ≥ 8 weeks, as measured by a score of ≥ 10 on the Epworth Sleepiness Scale;
 - B. If age is < 11 years, all of the following:
 1. Has had a consultation with a pediatric neurologist, pediatric pulmonologist, or pediatric sleep medicine specialist, and the MSLT has been ordered by the consulting physician;
 2. The MSLT will be conducted in a facility specializing in pediatric sleep disturbances with pediatric consultants available;
 - C. A standard PSG is planned for the night before the MSLT;
 - D. Suspected idiopathic hypersomnia; or suspected narcolepsy and any of the following:
 1. Cataplexy (brief, sudden loss of muscle tone);
 2. Hypnagogic and/or hypnopompic hallucinations;
 3. Sleep paralysis;
 - E. Medical conditions considered and treated, if indicated;
 - F. Medications deemed noncontributory;
 - G. No psychiatric disorder by history, or psychiatric disorder is under the care of a psychiatrist or psychologist;
 - H. Drug and alcohol misuse excluded.

- II. It is the policy of health plans affiliated with Centene Corporation that repeat MSLT is **medically necessary** for ages two years and above when meeting criteria in section I. are met and at least one of the following:
 - A. The initial test findings are invalid or uninterpretable;
 - B. The initial test is affected by extraneous circumstances or appropriate study conditions were not present during initial testing;
 - C. The patient is suspected to have narcolepsy, but previous MSLT evaluation did not provide polygraphic confirmation.

Background

The multiple sleep latency test (MSLT) consists of four or five 20-minute nap opportunities at two-hour intervals throughout the day, while recording EEG and other parameters comparable to a PSG. The test is based on the belief that the speed with which one falls asleep is an indication of the severity of sleepiness and is conducted on the day following an overnight PSG.¹¹ The MSLT is indicated as part of the evaluation of patients with suspected narcolepsy and may be useful in the evaluation of patients with suspected idiopathic hypersomnia.^{1,8,13}

During the MSLT, a sleep latency time of less than five minutes is distinctly abnormal and supports a diagnosis of narcolepsy or severe sleep deprivation. The International Classification of Sleep Disorders, 3rd edition (ICSD-3), requires a mean sleep latency of less than eight minutes and two or more sleep onset REM periods as part of the diagnostic criteria for narcolepsy. Prepubertal children tend to have a somewhat longer sleep latency on the MSLT compared with adults, such that values of 8 to 15 minutes (rather than less than eight minutes) on the MSLT may suggest pathologic sleepiness.^{1,11}

Narcolepsy has been reported in children as young as 2 years; however, the peak onset is 15 years, with a less pronounced peak at 36 years. The classic pentad of narcolepsy consists of EDS (excessive daytime sleepiness), cataplexy, hypnagogic and/or hypnopompic hallucinations, disrupted nocturnal sleep, and sleep paralysis. Children rarely manifest all 5 classic symptoms; restlessness and over-activity may be more common than EDS. Academic deterioration, inattentiveness, and emotional lability are common. Serial MSLTs may be required for diagnosis, and multiple confounding factors may be involved.

Diagnosing narcolepsy in children presents several challenges. Clinical manifestations of sleep problems can vary by age and developmental level with further variations within pediatric age groups. There are consistent data showing the diagnostic utility of MSLT in school-aged children as young as 5 years with suspected narcolepsy.^{1,14} Studies show MSLT is a highly sensitive test in this population, with sensitivity for diagnosing narcolepsy ranging from 79% to 100%.^{1,13}

The same standard criteria used for adults are used for MSLT in children and studies are scored similarly, using the same normative data. However, special issues exist regarding performance, interpretation, and operating characteristics of MSLT in children. Studies demonstrated that developmentally normal, prepubertal, school-aged children seldom become sleepy during the standard 20-minute daytime nap timeframe; yet adolescents often can fall asleep on MSLT.¹³ As a result, some studies extended the nap timeframe from the usual 20 minutes to 30 minutes. As young children have a long sleep latency, research is needed to determine whether nap opportunities longer than the standard 20 minutes would better evaluate sleepiness in prepubertal children.¹³ A repeat MSLT may be indicated if the initial test was affected by inappropriate study conditions, the results are unclear or uninterpretable, or the test failed to confirm a diagnosis of narcolepsy despite strong clinical suspicion.⁵ Children with suspected narcolepsy must be evaluated by a pediatric neurologist, pulmonologist, or sleep medicine specialist.²

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Coding Implications

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CPT® Codes	Description
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness.

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
G47.11	Idiopathic hypersomnia with long sleep time
G47.12	Idiopathic hypersomnia without long sleep time
G47.31	Primary central sleep apnea
G47.33	Obstructive sleep apnea (adult) (pediatric)
G47.37	Central sleep apnea in conditions classified elsewhere
G47.411	Narcolepsy with cataplexy
G47.419	Narcolepsy without cataplexy
G47.421	Narcolepsy in conditions classified elsewhere with cataplexy
G47.429	Narcolepsy in conditions classified elsewhere without cataplexy
G47.53	Recurrent isolated sleep paralysis
G47.61	Periodic limb movement disorder
R46.3	Overactivity

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy approved		10/08
Removed specific InterQual and MCG guideline references References reviewed and updated Specialist review- pediatric neurology	05/14	05/14
Bulleted out Policy/Criteria section, added specific criteria to B rather than reference to external criteria	05/15	05/15
Removed revision history prior to 2014.	05/16	05/16

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
Added requirement that requests for children < 5 years be evaluated by a medical director; allowed MSLT to be ordered by pediatric neurologist, pulmonologist, or sleep medicine specialist; updated background description of narcolepsy to include hypnopompic hallucinations and disrupted nocturnal sleep.		
Changed policy to apply to ages 2 + (previously applied to ages 5-18). Removed portion of description noting that requests under age 5 need to be reviewed by the medical director. Added requirements for: excessive daytime sleepiness, as measured by 10 on ESS; that suspected narcolepsy should be in conjunction with any of the following: cataplexy, hypnagogic/ hypnopompic hallucinations, or sleep paralysis; that medical conditions should be treated if indicated, psychiatric disorders treated if present, medications deemed noncontributory, and drug or alcohol misuse excluded. CPT, HCPCS, and ICD-10 codes added.	04/17	05/17
Clarified language in criteria with the following: added Pediatric pulmonologist under I.B.1; added with consultant pediatrics available under I.B.2; added under the care of a psychiatrist or psychologist instead of ‘managed’ under I.G.	10/17	
References reviewed and updated.	04/18	04/18
Minor wording changes for clarity.	06/18	
References reviewed and updated	04/19	04/19
Deleted codes 95810 and 95811 as they are informational only (for PSG)	05/19	
References reviewed and updated. Specialist review.	03/20	04/20
Replaced all instances of “member” with “member/enrollee.” References reviewed and updated.	03/21	04/21
Annual review. Added criteria for repeat MSLT in section II. Updated additional background information with no further impact to criteria. References reviewed and updated. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Specialist reviewed.	04/22	04/22

References

1. Aurora RN, Lamm CI, Zak RS, et al. Practice parameters for the non-respiratory indications for polysomnography and multiple sleep latency testing for children. *Sleep*. 2012;35(11):1467-1473. Published 2012 Nov 1. doi:10.5665/sleep.2190
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4. Chervin RD. Idiopathic hypersomnia. UpToDate. www.uptodate.com. Updated January 31, 2022. Accessed March 7, 2022.

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6. Kirsch D. Stages and architecture of normal sleep. UpToDate. www.uptodate.com. Updated November 8, 2021. Accessed March 7, 2022.
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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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