Clinical Policy: Multiple Sleep Latency Testing

Reference Number: LA.CP.MP.24
Last Review Date: 08/20

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Multiple Sleep Latency Testing (MSLT) is part of the routine evaluation of patients suspected of having narcolepsy or idiopathic hypersomnia. It objectively measures an individual's tendency to fall asleep. It is considered the standard measurement of sleepiness and has proven to be a sensitive and reproducible test for quantifying sleepiness. It is not a part of the routine evaluation for other sleep disorders. A polysomnogram (PSG) should be conducted prior to the MSLT, and should not demonstrate significant sleep pathology (e.g., obstructive sleep apnea, central sleep apnea, etc.) in order to justify and validate a MSLT.

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections that MSLT is medically necessary for ages 2 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.

Background

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, cataplexy, hypnagogic and/or hypnopompic hallucinations, disrupted nocturnal sleep, and sleep paralysis. Children rarely manifest all 5 classic symptoms. They often deny EDS, and restlessness and over-activity sometimes predominate. Academic deterioration, inattentiveness, and emotional lability are common. Serial MSLTs may be required for diagnosis, and usually multiple confounding factors are involved.

Diagnosing narcolepsy in children presents a number of difficulties. Even within age groups of children, clinical manifestations of sleep problems can vary by age and developmental level. There are consistent data showing the diagnostic utility of MSLT in school-aged children as young as 5 years with suspected narcolepsy. Studies show MSLT is a highly sensitive test in this population, with sensitivity for diagnosing narcolepsy ranging from 79% to 100%.[1]

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. Children with suspected narcolepsy must be evaluated by a pediatric neurologist, pulmonologist, or sleep medicine specialist.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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

ICD-10-CM Code	Description
R46.3	Over activity

Reviews, Revisions, and Approvals	Date	Approval Date
Converted corporate to local policy.	08/15/2020	

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, Vol. 35, No. 11, 2012.
2. Bozorg AM, Benbadis SR. Narcolepsy. Apr 15, 2015. EMedicine from WebMD. Medscape, 2016.
3. Chervin RD. Approach to the patient with excessive daytime sleepiness. In: UpToDate, Scammell TE (Ed.), UpToDate, Waltham, MA. Accessed 03/11/20.
4. Chervin RD. Idiopathic hypersomnia. In: UpToDate, Scammell TE (Ed), UpToDate, Waltham, MA. Accessed 03/11/20.
5. Freedman N. Quantifying sleepiness. Harding SM (Ed). In: UpToDate, Waltham, MA. Accessed 3/11/2020.
6. Kirsch D. Stages and architecture of normal sleep. In: UpToDate, Harding SM (Ed), UpToDate, Waltham, MA. Accessed 03/11/20.
7. Kotagal S. Narcolepsy in Children. In: UpToDate, Scammell TE, Chervin RD (Ed), UpToDate, Waltham, MA. Accessed 03/11/20.
8. Littner MR, Kushida C, Wise M, et al. Practice parameters for clinical use of the multiple sleep latency test and the maintenance of wakefulness test. The clinical use of the MSLT and MWT-AASM Practice Parameters. Sleep. 2005;28(1):113-121.
9. Marcus CL, et al. Diagnosis and management of childhood obstructive sleep apnea syndrome. Pediatrics Vol. 130 No. 3 September 2012.
10. Thorpy MJ. The clinical use of the multiple sleep latency test. The Standards of Practice Committee of the American Sleep Disorders Association. Sleep. 1992;15(3):268-276.
11. Wise MS, Glaze DG. Assessment of sleep disorders in children. In UpToDate, Chervin RD (Ed), UpToDate, Waltham, MA. Accessed 03/11/20.
12. Smith, MA, PhD, Michael T., et.al. Use of Actigraphy for the Evaluation of Sleep Disorders and Circadian Rhythm Sleep-Wake Disorders: An American Academy of Sleep clinical practice guideline. J Clin Sleep Med. 2018;14(7):1231–1237.

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. LHCC 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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

©2020 Louisiana Healthcare Connections. All rights reserved. All materials are exclusively owned by Louisiana Healthcare Connections and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Louisiana Healthcare Connections. You may not alter or remove any trademark, copyright or other notice contained herein. Louisiana Healthcare Connections is a registered trademark exclusively owned by Louisiana Healthcare Connections.