MEDICAL POLICY

POLICY TITLE	POLYSOMNOGRAPHY FOR NON–RESPIRATORY SLEEP DISORDERS
POLICY NUMBER	MP 2.335

CLINICAL BENEFIT	☒ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**2/1/2026**

POLICY

Polysomnography (PSG) and a multiple sleep latency test performed on the day after the PSG may be considered **medically necessary** in the evaluation of suspected narcolepsy or idiopathic hypersomnia.

PSG may be **medically necessary** when evaluating individuals with parasomnias when there is a history of sleep related injurious or potentially injurious disruptive behaviors.

PSG may be **medically necessary** when a diagnosis of periodic limb movement disorder (PLMD) is considered when there is:

- A complaint of repetitive limb movement during sleep by the individual or an observer; and
- No other concurrent sleep disorder; and
- At least one of the following is present:
  - Frequent awakenings; or
  - Fragmented sleep; or
  - Difficulty maintaining sleep; or
  - Excessive daytime sleepiness.

PSG for the diagnosis of PLMD is considered **investigational** when there is:

- Concurrent untreated obstructive sleep apnea; or
- Restless legs syndrome; or
- Narcolepsy; or
- Rapid eye movement (REM) sleep behavior disorder.

There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

PSG is considered **investigational** for the diagnosis of non–respiratory sleep disorders not meeting the criteria above, including but not limited to:

- Nightmare disorder; or
- Depression; or
- Sleep-related bruxism; or
- Noninjurious disorders of arousal.

There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

POLICY GUIDELINES

This policy addresses Polysomnography (PSG) for non–respiratory sleep disorders, which include the hypersomnias (e.g., narcolepsy), parasomnias, and sleep-related movement disorders (e.g., restless legs syndrome [RLS], periodic limb movement disorder [PLMD]). PSG for obstructive sleep apnea is addressed in **MP 2.045 Diagnosis of Obstructive Sleep Apnea**.

Criteria is meant for attended PSG to be completed in a facility for the medically necessary conditions described above.

Cross-reference:

MP 1.128 Surgical Treatment of Snoring and Obstructive Sleep Apnea
MP 2.045 Diagnosis of Obstructive Sleep Apnea
MP 6.064 Medical Management of Obstructive Sleep Apnea Syndrome

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

DESCRIPTION/BACKGROUND

Hypersomnias

The hypersomnias include such disorders as narcolepsy, Klein-Levine syndrome, and idiopathic hypersomnolence. Narcolepsy is a neurologic disorder characterized predominantly by abnormalities of rapid eye movement (REM) sleep, some abnormalities of non-REM (NREM) sleep, and the presence of excessive daytime sleepiness that cannot be fully relieved by any amount of sleep. The classic symptoms include hypersomnolence, cataplexy, sleep paralysis, and hypnagogic (onset of sleep) hallucinations. Cataplexy refers to the total or partial loss of muscle tone in response to sudden emotion. Most patients with cataplexy have abnormally low levels of hypocretin-1 (orexin-A) in the cerebrospinal fluid. Narcolepsy type 1 (narcolepsy with cataplexy) is defined as excessive daytime sleepiness and at least one of the following criteria: (a) hypocretin deficiency or (b) cataplexy and a positive multiple sleep latency test (MSLT). During the MSLT, the patient lies down in a dark, quiet room to assess the time to enter the different stages of sleep. The test is repeated every 2 hours throughout the day, and the maximum time allowed to fall asleep is typically set at 20 minutes. Patients with narcolepsy often have a mean sleep latency of fewer than 5 minutes and 2 or more early-onset REM periods during the MSLT naps. People with idiopathic hypersomnia fall asleep easily but typically do not reach REM sleep during the MSLT. Narcolepsy type 2 (narcolepsy without

cataplexy) is defined by chronic sleepiness plus a positive MSLT; hypocretin-1 levels are in the normal range in most patients.

Parasomnias

Parasomnias are abnormal behavioral, experiential, or physiologic events that occur during entry into sleep, within sleep, or during arousals from sleep. Parasomnias can result in a serious disruption of sleep-wake schedules. Some, particularly sleepwalking, sleep terrors, and REM sleep behavior disorder (RBD), can cause injury to the patient and others. Parasomnias are classified into parasomnias associated with REM sleep, parasomnias associated with NREM sleep, and other parasomnias.

Parasomnias Associated with REM Sleep

Normally, REM sleep is accompanied by muscle atonia, in which there is almost complete paralysis of the body through inhibition of motor neurons. In patients with RBD, muscle tone is maintained during REM sleep. This can lead to abnormal or disruptive behaviors associated with vivid dreams such as talking, laughing, shouting, gesturing, grabbing, flailing arms, punching, kicking, sitting up or leaping from bed, and running. Violent episodes that carry a risk of harm to the patient or bed partner may occur up to several times nightly. Idiopathic RBD is associated with the development of degenerative synucleinopathies (Parkinson disease, dementia with Lewy bodies, multiple systems atrophy) in about half of patients. Guidelines recommend maintaining a safe sleeping environment for both the patient and bed partner along with medical therapy. Other parasomnias associated with REM sleep are recurrent isolated sleep paralysis and nightmare disorder.

Parasomnias Associated with NREM Sleep

Disorders of arousal from NREM sleep result from the intrusion of wake into NREM sleep. These include confusional arousals, sleepwalking, and sleep terrors. In these parasomnias, the patient has an incomplete awakening from NREM sleep, usually appears awake with eyes open, is unresponsive to external stimuli, and is amnestic to the event. Sleepwalking can range from calm behaviors such as walking through a house to violent and/or injurious behaviors such as jumping out of a second story window. Patients with sleep terrors (also called night terrors) typically awaken with a loud scream and feeling of intense fear, jump out of bed, and occasionally may commit a violent act.

Other Parasomnias

The category of "other parasomnias" has no specific relation to sleep stage and includes sleep-related dissociative disorders, sleep-related enuresis, sleep-related groaning, exploding head syndrome, sleep-related hallucinations, and a sleep-related eating disorder. Diagnosis of these disorders is primarily clinical, although polysomnography (PSG) may be used for differential diagnosis.

- In sleep-related dissociative disorders, behaviors occur during an awakening, but the patient is amnestic to them.
- Sleep-related enuresis (bedwetting) is characterized by recurrent involuntary voiding in patients greater than 5 years of age.

- Sleep-related groaning is a prolonged vocalization that can occur during either NREM or REM sleep.
- Exploding head syndrome is a sensation of a sudden loud noise or explosive feeling within the head on falling asleep or during awakening from sleep.
- Sleep-related hallucinations are hallucinations that occur on falling asleep or on awakening.
- Sleep-related eating disorder is characterized by recurrent episodes of arousals from sleep with involuntary eating or drinking. Patients may have several episodes during the night, typically eat foods that they would not eat during the day and may injure themselves by cooking during sleep.

Sleep-Related Movement Disorders
Sleep-related movement disorders include restless legs syndrome (RLS) and periodic limb movement disorder (PLMD).

Restless Legs Syndrome
RLS is a neurologic disorder characterized by uncomfortable or odd sensations in the leg that usually occur during periods of relaxation, such as while watching television, reading, or attempting to fall asleep. Symptoms occur primarily in the evening. The sensations are typically described as creeping, crawling, itchy, burning, or tingling. There is an urge to move in an effort to relieve these feelings, which may be partially relieved by activities such as rubbing or slapping the leg, bouncing the feet, or walking around the room.

Periodic Limb Movement Disorder
Periodic limb movements are involuntary, stereotypic, repetitive limb movements during sleep, which most often occur in the lower extremities, including the toes, ankles, knees, and hips, and occasionally in the upper extremities. The repetitive movements can cause fragmented sleep architecture, with frequent awakenings, a reduction in slow-wave sleep and decreased sleep efficiency, leading to excessive daytime sleepiness. PLMD alone is thought to be rare because periodic limb movements are typically associated with RLS, RBD, or narcolepsy and represent a distinct diagnosis from PLMD.

Diagnosis
PSG is a recording of multiple physiologic parameters relevant to sleep. The standard full polysomnogram includes:

- Electroencephalography to differentiate the various stages of sleep and wake,
- Chin electromyography and electrooculography to assess muscle tone and detect REM sleep,
- Respiratory effort, airflow, blood oxygen saturation (oximetry), and electrocardiography to assess apneic events,
- Anterior tibialis electromyogram to assess periodic limb movements during sleep, and
- Video recording to detect any unusual behavior.

Regulatory Status

A large number of PSG devices have been approved since 1986. U.S. Food and Drug Administration product code: OLV.

RATIONALE

SUMMARY OF EVIDENCE

Hypersomnia

For individuals who have suspected hypersomnia who receive PSG, the evidence includes a systematic review on diagnostic accuracy. Relevant outcomes are test accuracy, symptoms, functional outcomes, and quality of life. The evidence has suggested that PSG followed by the multiple sleep latency test is associated with moderate sensitivity and high specificity in support of the diagnosis of narcolepsy. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Parasomnias

For individuals who have typical or benign parasomnia who receive PSG, the evidence includes systematic reviews of studies on diagnostic accuracy and controlled cohort studies. Relevant outcomes are test accuracy, symptoms, functional outcomes, and quality of life. The evidence has suggested that typical and benign parasomnias (e.g., sleepwalking, sleep terrors) may be diagnosed on the basis of their clinical features and do not require PSG. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have violent or potentially injurious parasomnia who receive PSG, the evidence includes systematic reviews of studies on diagnostic accuracy and controlled cohort studies. Relevant outcomes are test accuracy, symptoms, functional outcomes, and quality of life. For the diagnosis of REM sleep behavior disorder, the combined use of clinical history and PSG to document the loss of muscle atonia during REM sleep increases diagnostic accuracy and is considered the criterion standard for diagnosis. Diagnostic accuracy is increased with videorecording during PSG to assess parasomnias such as REM sleep behavior disorder. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Sleep-Related Movement Disorders

For individuals who have restless legs syndrome who receive PSG, the evidence includes systematic reviews of studies on diagnostic accuracy and controlled cohort studies. Relevant outcomes are test accuracy, symptoms, functional outcomes, and quality of life. Restless legs syndrome does not require PSG because the syndrome is a sensorimotor disorder, the symptoms of which occur predominantly when awake; therefore, PSG results are generally not useful. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have periodic limb movement disorder who receive PSG, the evidence includes a systematic review. Relevant outcomes are test accuracy, symptoms, functional outcomes, and quality of life. PSG with electromyography of the anterior tibialis is the only

method available to diagnose periodic limb movement disorder, but this sleep-related movement disorder is rare and should only be evaluated using PSG in the absence of symptoms of other disorders. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

DEFINITIONS

NA

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These polices are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes								
95782	95783	95805	95808	95810	95811			

ICD-10-CM Diagnosis Code	Description
G47.11	Idiopathic hypersomnia with long sleep time
G47.12	Idiopathic hypersomnia without long sleep time
G47.13	Recurrent hypersomnia
G47.411	Narcolepsy with cataplexy
G47.419	Narcolepsy without cataplexy
G47.50	Parasomnia, unspecified
G47.51	Confusional arousals

ICD-10-CM Diagnosis Code	Description
G47.52	REM sleep behavior disorder
G47.53	Recurrent isolated sleep paralysis
G47.54	Parasomnia in conditions classified elsewhere
G47.59	Other parasomnia
G47.61	Periodic limb movement disorder

REFERENCES

1. *Kushida CA, Littner MR, Morgenthaler T, et al. Practice parameters for the indications for polysomnography and related procedures: an update for 2005. Sleep. Apr 2005; 28(4): 499-521. PMID 16171294*
2. *Aurora RN, Zak RS, Maganti RK, et al. Best practice guide for the treatment of REM sleep behavior disorder (RBD). J Clin Sleep Med. Feb 15, 2010; 6(1): 85-95. PMID 20191945*
3. *Aurora RN, Kristo DA, Bista SR, et al. The treatment of restless legs syndrome and periodic limb movement disorder in adults--an update for 2012: practice parameters with an evidence-based systematic review and meta-analyses: an American Academy of Sleep Medicine Clinical Practice Guideline. Sleep. Aug 01, 2012; 35(8): 1039-62. PMID 22851801*
4. *Chesson AL, Ferber RA, Fry JM, et al. The indications for polysomnography and related procedures. Sleep. Jun 1997; 20(6): 423-87. PMID 9302726*
5. *Drakatos P, Marples L, Muza R, et al. Video polysomnographic findings in non-rapid eye movement parasomnia. J Sleep Res. Apr 2019; 28(2): e12772. PMID 30295353*
6. *Neikrug AB, Ancoli-Israel S. Diagnostic tools for REM sleep behavior disorder. Sleep Med Rev. Oct 2012; 16(5): 415-29. PMID 22169258*
7. *Goldstein CA. Parasomnias. Dis Mon. Jul 2011; 57(7): 364-88. PMID 21807161*
8. *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. Nov 01, 2012; 35(11): 1467-73. PMID 23115395*
9. *Winkelman JW, Berkowski JA, DelRosso LM, et al. Treatment of restless legs syndrome and periodic limb movement disorder: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. Jan 01 2025; 21(1): 137-152. PMID 39324694*
10. *Aurora RN, Zak RS, Auerbach SH, et al. Best practice guide for the treatment of nightmare disorder in adults. J Clin Sleep Med. Aug 15, 2010; 6(4): 389-401. PMID 20726290*
11. *Morgenthaler TI, Auerbach S, Casey KR, et al. Position Paper for the Treatment of Nightmare Disorder in Adults: An American Academy of Sleep Medicine Position Paper. J Clin Sleep Med. Jun 15, 2018; 14(6): 1041-1055. PMID 29852917*
12. *Cesari M, Heidbreder A, St Louis EK, et al. Video-polysomnography procedures for diagnosis of rapid eye movement sleep behavior disorder (RBD) and the identification of*

its prodromal stages: guidelines from the International RBD Study Group. Sleep. Mar 14, 2022; 45(3). PMID 34694408

13. *Howell M, Avidan AY, Foldvary-Schaefer N, et al. Management of REM sleep behavior disorder: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. Apr 01 2023; 19(4): 759-768. PMID 36515157*

POLICY HISTORY

MP 2.335	**04/21/2020 Consensus Review**. No change to policy statement. References reviewed and updated. Coding reviewed and unchanged.
	10/11/2021 Consensus Review. No change to policy statement. References reviewed. FEP updated. No coding changes
	09/01/2022 Consensus Review. Background and references updated. Updated ICD-10 table.
	09/26/2023 Consensus Review. Updated background and references. No changes to coding.
	10/10/2024 Consensus Review. Minor editorial refinements to policy statement. No change to intent. Updated rationale and references. No changes to coding.
	07/29/2025 Minor Review. Removed the word “untreated” from the statement “No other concurrent untreated sleep disorder”. NMN updated to INV and notes moved to policy guidelines. Updated policy guidelines, background, and references. No changes to coding.