MEDICAL POLICY – 2.01.99

Polysomnography for Non–Respiratory Sleep Disorders

Effective Date: Mar. 1, 2017
Last Revised: Feb. 14, 2017
Replaces: N/A

RELATED MEDICAL POLICIES:
2.01.503 Polysomnography and Home Sleep Study for Diagnosis of Obstructive Sleep Apnea

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Introduction

A sleep study records several different bodily processes as you sleep. A full sleep study looks at the stages of waking and sleeping, rapid eye movement, the effort it takes to breathe, airflow, oxygen in the blood, whether breathing stops for short periods, or unusual movement or behavior. Most sleep studies look at whether a person stops breathing for short periods of time during sleep. There are other sleep problems, though, related to unusual movement or behaviors. These are generally called sleep-related movement disorders. This policy discusses when a sleep study may be covered for a suspected sleep-related movement disorder.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Investigational Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polysomnography (PSG)</td>
<td>Polysomnography (PSG) is considered investigational for the diagnosis of non–respiratory sleep disorders not meeting the criteria in this policy, including but not limited to nightmare</td>
</tr>
</tbody>
</table>
disorder, depression, sleep-related bruxism, or noninjurious disorders of arousal.

<table>
<thead>
<tr>
<th>Purpose / Condition</th>
<th>Medically Necessary Coverage Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected narcolepsy idiopathic hypersomnia</td>
<td>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.</td>
</tr>
<tr>
<td>Parasomnias</td>
<td>PSG may be considered medically necessary when evaluating patients with parasomnias when there is a history of sleep related injurious or potentially injurious disruptive behaviors.</td>
</tr>
</tbody>
</table>
| Periodic limb movement disorder (PLMD)    | 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 patient or an observer  
  AND  
  • There is no other concurrent sleep disorder  
  AND  
  • At least one of the following is present:  
    o Frequent awakenings  
    o Fragmented sleep  
    o Difficulty maintaining sleep  
    o Excessive daytime sleepiness  

  PSG for the diagnosis of PLMD is considered not medically necessary when there is concurrent untreated obstructive sleep apnea, restless legs syndrome, narcolepsy, or rapid eye movement sleep behavior disorder. |

Coding

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95805</td>
<td>Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess</td>
</tr>
</tbody>
</table>
CPT

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95808</td>
<td>Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist</td>
</tr>
<tr>
<td>95810</td>
<td>Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.</td>
</tr>
<tr>
<td>95811</td>
<td>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.</td>
</tr>
<tr>
<td>95782</td>
<td>Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist</td>
</tr>
<tr>
<td>95783</td>
<td>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.</td>
</tr>
</tbody>
</table>

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Related Information

Polysomnography (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 (EMG) and electrooculography to assess muscle tone and detect rapid eye movement (REM) sleep
- Respiratory effort, airflow, blood oxygen saturation (oximetry), and electrocardiography to assess apneic events
- Anterior tibialis EMG to assess periodic limb movements during sleep
- Video recording to detect any unusual behavior
Hypersomnias

The hypersomnias include such disorders as narcolepsy, Klein-Levine syndrome, and idiopathic hypersomnolence. Narcolepsy is a neurologic disorder characterized predominantly by abnormalities of 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 1 of the following criteria: (a) hypocretin deficiency or (b) cataplexy and a positive multiple sleep latency test (MSLT). In 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 sleep is typically set at 20 minutes. Patients with narcolepsy often have a mean sleep latency of less 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 and family functioning. 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 non-REM (NREM) sleep, and other parasomnias.

Parasomnias Associated with REM Sleep

REM sleep is normally accompanied by muscle atonia, in which there is an 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 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 sleep-related eating disorder. Diagnosis of these disorders is primarily clinical, although 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 upon falling asleep or during an 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.³
Description

Polysomnography (PSG) recordings multiple physiologic parameters relevant to sleep. Video recording may also be performed during PSG to assess parasomnias such as rapid eye movement (REM) sleep behavior disorder (RBD).

Evidence Review

The objective of this evidence review is to address polysomnography for non–respiratory sleep disorders, which include the hypersomnias (e.g., narcolepsy), parasomnias (e.g., sleep terrors, sleepwalking, rapid eye movement sleep behavior disorder) and movement disorders (e.g., restless legs syndrome, periodic limb movement disorder).

Hypersomnia

Evidence reviewed by AASM included a data review of 1602 patients, of whom 176 patients had narcolepsy and 1426 had other sleep disorders. However, 7% of obstructive sleep apnea patients and 5% of other sleep disorders patients had 2 sleep onset REMs (SOREMs) on multiple sleep latency test (MSLT), leading to a low predictive value for narcolepsy. No data were found that validated the maintenance of wakefulness test (which measures a patient’s ability to stay awake in a quiet sleep-inducing environment), limited or partial polysomnography (PSG), portable recording, isolated MSLT, or separately performed PSG and MSLT as an alternative to the criterion standard of nocturnal PSG with an MSLT on the following day for the diagnosis of narcolepsy. The 2005 evidence review found that the presence of 2 or more early sleep-onset latency episodes was associated with a sensitivity of 0.78 and specificity of 0.93 for the diagnosis of narcolepsy. Based on the evidence reviewed, the updated 2005 AASM guidelines indicated that PSG should be used to rule out other potential causes of sleepiness followed by an MSLT to confirm the clinical impression of narcolepsy. These tests assume greater significance if cataplexy is lacking. In the absence of cataplexy and when there is one or more of the other symptoms, the laboratory criteria are required to establish the diagnosis of narcolepsy.

For individuals who have suspected hypersomnia who receive polysomnography (PSG), the evidence includes a systematic review on diagnostic accuracy. Relevant outcomes are test accuracy, symptoms, functional outcomes, and quality of life. Evidence indicates 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.
Parasomnia

**Typical or Benign Parasomnia**

Evidence reviewed by AASM in 1997 indicated that typical sleepwalking or sleep terrors, with onset in childhood, a positive family history, occurrence during the first third of the night, amnesia for the events, prompt return to sleep following the events, and relatively benign automatistic behaviors, may be diagnosed on the basis of their historical clinical features. This conclusion was based on very consistent descriptive literature (case series and cohort studies).

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 indicates 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 sufficient to determine that the technology is unlikely to improve the net health outcome.

**Violent or Potentially Injurious Parasomnia**

When events are not typical of benign partial arousals and where other diagnoses, prognoses, and interventions should be considered, PSG was recommended by AASM. The evidence reviewed in 1997 included only 3 articles on disorders of arousal and 2 for REM sleep behavior disorder (RBD) that included comparison data for normal controls. Most articles supporting the utility of PSG were limited by biases inherent in uncontrolled clinical reports. The need for PSG was also indicated in a 2011 review of parasomnias that concluded, although RBD is the only parasomnia that requires PSG for diagnosis, PSG may be needed to rule out another sleep pathology, such as sleep-disordered breathing or periodic limb movements (PLMs) of sleep, that might cause a parasomnia. Evidence reviewed in a 2010 AASM best practice guide indicated that sleep-related injuries are a significant portion of the morbidity in RBD, with a prevalence in diagnosed RBD patients ranging from 30% to 81%. Types of injuries ranged from ecchymoses and lacerations to fractures and subdural hematomas, with ecchymoses and lacerations being significantly more common than fractures. In a series of 92 patients, 64% of the bed partners sustained punches, kicks, attempted strangulation, and assault with objects. Minimal diagnostic criteria for RBD requires the presence of REM sleep without atonia, defined as sustained or intermittent elevation of submental electromyogram (EMG) tone or excessive phasic muscle activity in the limb EMG. Two clinical series with over 100 cases each of patients with various parasomnias found that PSG had an overall yield of clinical utility in 65% and 91% of cases. A
systematic review on the diagnosis of RBD found that diagnostic accuracy is increased with combined use of clinical history and video PSG to document the intermittent or sustained loss of muscle atonia or actual observation of RBD occurrences.\(^7\)

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 rapid eye movement (REM) sleep behavior disorder (RBD), combined use of clinical history and PSG to document loss of muscle atonia during REM sleep increases diagnostic accuracy and is considered the criterion standard for diagnosis. Diagnostic accuracy is increased with video recording during PSG to assess parasomnias such as RBD. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Sleep-Related Movement Disorder**

*Restless Legs Syndrome*

The 4 cardinal diagnostic features of restless legs syndrome (RLS) include (1) an urge to move the limbs that is usually associated with paresthesias or dysesthesias, (2) symptoms that start or worsen with rest, (3) at least partial relief of symptoms with physical activity, and (4) worsening of symptoms in the evening or at night.\(^3\) Evidence reviewed by AASM included a case-control study that found, compared with controls, RLS patients had reduced total sleep time, reduced sleep efficiency, prolonged sleep latencies, decreased slow-wave sleep, and increased nocturnal awakening. However, because the principal symptoms of RLS occur during wake, RLS does not require PSG for diagnosis, except where uncertainty exists in the diagnosis.\(^1,5\) RLS frequently also has a primary motor symptom that is characterized by the occurrence of periodic limb movements (PLMs) in sleep. PLMs occur in 80% to 90% of patients who have RLS and support the diagnosis of RLS. In cases of frequent PLMs during PSG and a subjective perception of poor sleep in the absence of RLS or sleep-related breathing disorder, periodic limb movement disorder (PLMD) can be diagnosed (see next).\(^3\)

For individuals who have restless legs syndrome (RLS) 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. RLS does not require PSG because RLS is a sensorimotor disorder, the symptoms of which occur predominantly when awake. Therefore, PSG results are generally not useful. The evidence is sufficient to determine that the technology is unlikely to improve the net health outcome.
Periodic Limb Movement Disorder

Evidence reviewed by AASM showed difficulty in diagnosing PLMD without PSG. In a series of 123 patients evaluated for chronic insomnia, a PLMD diagnosis was confirmed in 5 patients and discovered with PSG in another 10 patients. The PLMD scale from a sleep questionnaire had low sensitivity and specificity. Actigraphy, evoked potentials, and blink reflexes have been found to have little diagnostic specificity or utility. PSG-based diagnosis of PLMD correlated best with frequent awakening at night. In a series of 1171 patients who had PSG at 1 sleep disorders center, 67 (6%) patients had PLMD as the primary and sole sleep diagnosis. The mean sleep efficiency was 53% and daytime sleepiness was reported by 60% of the cohort. The PLMD patients reported disturbed sleep during a mean of 4 nights per week for a mean of 7 years.

For individuals who have periodic limb movement disorder (PLMD) 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 PLMD, 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.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in October 2016 did not identify any ongoing or unpublished trials that would likely influence this review.

Practice Guidelines and Position Statements

American Academy of Sleep Medicine

In 2005, the American Academy of Sleep Medicine (AASM) published practice parameters for polysomnography (PSG) and related procedures. AASM made the following recommendations on the use of PSG for nonrespiratory indications (see Table 1).
Table 1: AASM Practice Parameters on PSG for Nonrespiratory Indications

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polysomnography and a multiple sleep latency test performed on the day after the polysomnographic evaluation are routinely indicated in the evaluation of suspected narcolepsy</td>
<td>Standard</td>
</tr>
<tr>
<td>Common, uncomplicated, noninjurious parasomnias, such as typical disorders of arousal, nightmares, enuresis, sleeptalking, and bruxism, can usually be diagnosed by clinical evaluation alone</td>
<td>Standard</td>
</tr>
<tr>
<td>Polysomnography is not routinely indicated in cases of typical, uncomplicated, and noninjurious parasomnias when the diagnosis is clearly delineated</td>
<td>Option</td>
</tr>
<tr>
<td>A clinical history, neurologic examination, and a routine EEG obtained while the patients is awake and asleep are often sufficient to establish the diagnosis and permit the appropriate treatment of a sleep related seizure disorder. The need for a routine EEG should be based on clinical judgment and the likelihood that the patient has a sleep relate seizure disorder</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography is not routinely indicated for patients with a seizure disorder who have no specific complaints consistent with a sleep disorder</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography is indicated when evaluating patients with sleep behaviors suggestive of parasomnias that are unusual or atypical because of the patient’s age at onset; the time, duration or frequency of occurrence of the behavior; or the specifics of the particular motor patterns in question</td>
<td>Guideline</td>
</tr>
<tr>
<td>Polysomnography is indicated in evaluating sleep related behaviors that are violent or otherwise potentially injurious to the patient or others</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography may be indicated in situations with forensic considerations (e.g., if onset follows trauma or if the events themselves have been associated with personal injury)</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography may be indicated when the presumed parasomnia or sleep related seizure disorder does not respond to conventional therapy</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography is indicated when a diagnosis of periodic limb movement disorder is considered because of complaints by the patient or an observer of repetitive limb movement during sleep and frequent awakenings, fragmented sleep, difficulty maintaining sleep, or excessive daytime sleepiness</td>
<td>Standard</td>
</tr>
<tr>
<td>Intra-individual night-to-night variability exists in patients with periodic limb movement sleep disorder, and a single study might not be adequate to establish this diagnosis</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography is not routinely indicated to diagnose or treat restless legs syndrome, except where uncertainty exists in the diagnosis</td>
<td>Standard</td>
</tr>
<tr>
<td>Polysomnography is not routinely indicated for the diagnosis of circadian rhythm sleep disorders</td>
<td>Standard</td>
</tr>
</tbody>
</table>

AASM: American Academy of Sleep Medicine; EEG: electroencephalography
In 2012, AASM published practice parameters for the nonrespiratory indications for PSG and multiple sleep latency testing in children. The following recommendations for PSG and MSLT were made (see Table 2).

### Table 2: AASM Practice Parameters on PSG for Nonrespiratory Indications in Children

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSG is indicated for children suspected of having periodic limb movement disorder (PLMD) for diagnosing PLMD</td>
<td>Standard</td>
</tr>
<tr>
<td>The MSLT, preceded by nocturnal PSG, is indicated in children as part of the evaluation for suspected narcolepsy</td>
<td>Standard</td>
</tr>
<tr>
<td>Children with frequent NREM parasomnias, epilepsy, or nocturnal enuresis should be clinically screened for the presence of comorbid sleep disorders and polysomnography should be performed if there is a suspicion for sleep-disordered breathing or periodic limb movement disorder</td>
<td>Guideline</td>
</tr>
<tr>
<td>The MSLT, preceded by nocturnal PSG, is indicated in children suspected of having hypersomnia from causes other than narcolepsy to assess excessive sleepiness and to aid in differentiation from narcolepsy</td>
<td>Option</td>
</tr>
<tr>
<td>The polysomnogram using an expanded EEG montage is indicated in children to confirm the diagnosis of an atypical or potentially injurious parasomnia or differentiate a parasomnia from sleep-related epilepsy when the initial clinical evaluation and standard EEG are inconclusive</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography is indicated in children suspected of having RLS who require supportive data for diagnosing RLS</td>
<td>Option</td>
</tr>
<tr>
<td>Polysomnography is not routinely indicated for evaluation of children with sleep-related bruxism</td>
<td>Standard</td>
</tr>
</tbody>
</table>

AASM: American Academy of Sleep Medicine; EEG: electroencephalography; MSLT: multiple sleep latency test; NREM: non-rapid eye movement; PSG: polysomnography; RLS: restless legs syndrome.

AASM issued a 2012 practice parameter on the treatment of restless legs syndrome (RLS) and periodic limb movement disorder in adults. The practice parameter noted many different treatment efficacy measures are used to assess RLS due to its multifaceted nature. Measures included a number of various subjective scales; the only objective measurements are sleep-related parameters by PSG or actigraphy.

AASM issued a 2010 Best Practice Guide on the treatment of nightmare disorders in adults (classified as a parasomnia). AASM states the overnight PSG is not routinely used to assess nightmare disorder but may be used to exclude other parasomnias or sleep-disordered
breathing. PSG may underestimate the incidence and frequency of posttraumatic stress disorder–associated nightmares.

AASM issued a 2010 best practice guide on the treatment of rapid eye movement sleep behavior disorder (RBD). Minimal diagnostic criteria for RBD included:

- Presence of REM sleep without atonia, defined as sustained or intermittent elevation of submental EMG [electromyographic] tone or excessive phasic muscle activity in the limb EMG;
- At least 1 of the following:
  - Sleep related injurious or potentially injurious disruptive behaviors by history;
  - Abnormal REM behaviors documented on polysomnogram (PSG);
- Absence of epileptiform activity during REM sleep unless RBD can be clearly distinguished from any concurrent REM sleep-related seizure disorder;
- Sleep disturbance not better explained by another sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder.

**Medicare National Coverage**

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

**Regulatory Status**

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

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**References**


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**History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/14/17</td>
<td>New policy. Created separate policy for non-respiratory sleep disorders. Policy statements previously included in 2.01.503 Polysomnography and Home Sleep Study for Diagnosis of Obstructive Sleep Apnea. Added to the Medicine section.</td>
</tr>
</tbody>
</table>

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Appellez le 800-722-1471 (TTY: 800-842-5357).


Ilokano (Ilocano): Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maihantayggit iti aplikasyonuwen no覆盖 cover babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a pelsa iti daytoy a pakdaar. Mabalin nga adda rumbeg nga aramidenyo nga addang sakbay dagiti partikular a na tinutud nga adlaw tapno mapagalataydoy nga tiyage ti salun-ayyo wenno tungol kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tungol iti bukodyo a pagasasa nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian): Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente.
Chiama 800-722-1471 (TTY: 800-842-5357).
Premera Blue Cross. Podería existir datos importantes en el aviso, por lo que es posible que haya fechas clave aquí.

Заголовок (Ukrainian): Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про ваше звернення щодо страхування через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні.