Sleep Study Prior Authorization Request Form

Phone: 866-827-5861  FAX: 866-536-8046
Portal: www.sleepsms.com or www.carecentrixportal.com

This form must be completed in its entirety for all faxed sleep diagnostic prior authorization requests. The most recent clinical notes and current medication list (medications the member has been prescribed for the last 30 days) must also accompany the faxed request. We recommend that all requests for sleep related services are submitted via our provider portal at: www.sleepsms.com or www.carecentrixportal.com.

I. Study Requested:
   Unattended Home Sleep Test (HST)   G0399
   Attended Facility Sleep Test
       95810 Diagnostic PSG
       95811 Split-Night PSG attended w/therapy
       95782 Diagnostic PSG age < 6 years
       95783 Full-Night Titration Study age < 6 years

   If the member does not meet medical criteria for an in-lab diagnostic sleep test but they meet criteria for a home sleep test, may a home sleep test be authorized? Yes ______ No ______ If No, supportive clinical evidence must be attached.

Is this request for a repeat Sleep Study? Yes ______ No ______

Does the member have a history of OSA? Yes ______ No ______
Is the member currently on therapy? Yes ______ No ______
Date of last sleep study: ________________

If the member had a prior sleep study, what sleep disorder(s) was the member previously diagnosed? ______________________________

Repeat study indication: Weight change >10% ______ Recent T/A or UPPP ______ Other (specify) ________________
Compliance for repeat studies: Is PAP used > 2 mos? Yes ______ No ______
Is patient using PAP device at least 70% of usage 4+ hours per 24 hour period? Yes ______ No ______
( Please provide the previous sleep study to include the raw data and the PAP therapy adherence data if patient on PAP therapy)

II. Required Clinical Information – Check ALL that apply in sections A through E

A. What is the indication (suspected diagnosis) for the sleep study?
   Obstructive Sleep Apnea (OSA) (G47.33) ______
   Central or treatment-emergent sleep apnea (G47.31, G47.37) ______
   REM sleep behavior disorder (G47.52) ______
   Narcolepsy (G47.411, G47.419) ______
   Potentially injurious of violent parasomnias (G47.50) ______
   Nocturnal Seizures (G40, G40.89) ______
   Periodic Limb Movement Disorder (PLMD) diagnosed on previous polysomnography (G47.61) ______
   Idiopathic hypersomnia (G47.11/G47.12) ______
   Other (Please Specify): __________________________
B. Signs & Symptoms  Initial testing for the diagnosis of sleep disordered breathing is appropriate if a member presents with at least one sign/symptom from category (a) AND one sign/symptom from category (b) below:

(a) Evidence of Excessive Daytime Sleepiness
   ____ Disturbed or restless sleep
   ____ Non-restorative sleep/non-refreshing sleep
   ____ Frequent unexplained arousals from sleep
   ____ Fragmented Sleep
   ____ Epworth sleepiness score greater than or equal to 10
   ____ Fatigue

Duration of signs & symptoms:
   _____ Less than one month   _____ Greater than one month

(b) Evidence Suggestive of Sleep Disordered Breathing
   ____ Witnessed apnea events
   ____ Habitual, loud snoring
   ____ Choking, gasping during sleep
   ____ Neck circumference > 17” in men, > 16 “ in women
   ____ Obesity (i.e. body mass index > 30)
   ____ Sleep related bruxism (clenching, grinding teeth)
   ____ Cognitive deficits such as inattention or memory
   ____ Unexplained night time reflux
   ____ Erectile dysfunction
   ____ Experienced Apneas/Hypoxemias under anesthesia
   ____ Morning headache

C. Co-morbid Conditions
   _____ Moderate to severe pulmonary hypertension with pulmonary artery pressure greater than 40 mm Hg
   _____ Moderate to severe congestive heart failure (NYHA Class III or IV) or LVEF less than or equal to 45%
   _____ Neuromuscular/neurodegenerative disorder causing restrictive lung disease, such as: severe kyphoscoliosis, myasthenia gravis, amyotrophic lateral sclerosis (ALS), post-polio syndrome, polymyositis, and Guillain-Barré syndrome
   _____ Chronic opioid medication use (provide a current medication list with opioid medications in use, including dose and frequency)
   _____ Acute, uncontrolled or refractory (resistant to treatment) cardiac arrhythmia(s) supported by clinical documentation
   _____ No known comorbid conditions

D. Suspected Other Sleep Disorders
   _____ Central Sleep apnea or treatment emergent sleep apnea defined as central apneas/hypopneas greater than 50% of the total apneas/hypopneas and central apneas/hypopneas greater than or equal to 5 times per hour
   _____ Narcolepsy or narcolepsy related symptoms (i.e. idiopathic hypersomnia) after obstructive sleep apnea has been evaluated and effectively treated as documented by the patient’s objective adherence to therapy (PAP download)
   _____ Nocturnal Seizures which are acute and/or not effectively controlled and occurring concomitantly with other sleep disorders
   _____ Previously diagnosed Periodic Limb Movement Disorder (PLMD) defined as greater than or equal to 15 periodic limb movements per hour resulting in arousal, when the arousals are not associated with respiratory events.
   _____ Complex parasomnias with potentially injurious, disruptive or violent behavior, such as REM Behavior Disorder or sleep walking
   _____ Obesity hypoventilation syndrome, defined as pCO2 greater than 45 mm Hg and pO2 less than 60 mm Hg on arterial blood gas

E. Epworth Sleepiness Score (ESS):
   What is the member’s Epworth sleepiness score? ________________
   (Please see ESS on page 3 for reference if needed)

III. Preferred sleep test provider(s), please list below (CareCentrix reserves the right to assign a provider):

   Billing Facility Name: Address: __________________________________________
   ___________ Phone: ___________ Fax: ___________ Tax ID: ___________ NPI: ___________

   HST Provider: ___________ Address: __________________________________________
   ___________ Phone: ___________ Fax: ___________ Tax ID: ___________ NPI: ___________

IV. Special Needs:
   Impaired cognition/dementia (please specify): __________________________________________
   Occupational or social limitations (please specify): __________________________________________
   Alternate Language Spoken (please specify): __________________________________________

V. [ ] By checking this box, I am verifying that the information provided is true and accurate.
   Name: __________________________________________ Date: ____________________
VI. Additional Notes:

VII. Epworth Sleepiness Score:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Never doze or sleep  1 = Slight chance of dozing or sleeping  2 = Moderate chance of dozing or sleeping  3 = High chance of dozing or sleeping

<table>
<thead>
<tr>
<th>Situation Chance of Dozing or Sleeping</th>
<th>Scale</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>Lying down to rest in the afternoon</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td>Sitting quietly after lunch (without alcohol)</td>
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<tr>
<td>Being a passenger in a car for an hour without a break</td>
<td>Sitting for a few minutes in traffic while driving</td>
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Total Score equals your ESS (0 - 9 Average score, normal population)

VIII. Reference Table of Codes and Descriptions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0399</td>
<td>Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation</td>
</tr>
<tr>
<td>95810</td>
<td>Polysomnography; age 18 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist</td>
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<tr>
<td>95811</td>
<td>Polysomnography, age 18 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist</td>
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<tr>
<td>95811</td>
<td>Split-night in-facility polysomnography, in which the initial diagnostic portion of the polysomnography is followed by positive airway pressure (PAP) titration, as medically necessary in an adult (age 18 or older)</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, attended by a technologist with an initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist</td>
</tr>
<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 sleepiness</td>
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