I. Study Requested:

Unattended Home Sleep Test (HST)
G0399 __________ G0398 __________ 95800 _______ 95801 _______ 95806 _______

Facility diagnostic sleep test

_____ 95807 Diagnostic PST, abbreviated study (note this is normally not covered by Cigna)
_____ 95808 Diagnostic PSG (3+ parameters)
_____ 95810 Diagnostic PSG (4+ parameters)
_____ 95782 Diagnostic PSG age < 6 years
_____ 95811 Split-Night PSG attended w/therapy

If the member does not meet Cigna’s 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.

Facility follow-up (second night) sleep test

II. Required Clinical Information – Check all that apply

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 or violent parasomnias (G47.50)
- _____ Nocturnal Seizures (G40, G40.89)
- _____ Periodic Limb Movement Disorder (PLMD) diagnosed on previous polysomnography (G47.61)
- _____ Other – Please Specify: _____________________________

(Please provide previous diagnostic test raw data)

_____ 95811 Full-Night Titration Study (CPAP)
_____ 95811 Full-Night Titration Study (Bi-level)
_____ 95811 Full-Night Titration Study (Bi-level w/ ASV)
_____ 95783 Full-Night Titration Study age < 6 years
_____ 95805 Multiple Sleep Latency Testing / PSG (MSLT)
_____ 95805 Maintenance of Wakefulness Test (MWT)

If the member does not meet Cigna’s criteria for an attended titration study but they meet criteria for an unattended auto-titrating positive airway pressure machine (APAP), may the APAP be authorized?
Yes _____ No _____
If No, supportive clinical evidence must be attached.
B. Complaint(s)

- Habitual snoring (R06.83)
- Excessive Daytime Sleepiness (EDS), i.e. disturbed or restless sleep non-restorative sleep/non E refreshing sleep
- Witnessed apnea events
- Choking during sleep
- Gasping while sleeping
- Increased neck circumference (i.e. > 17 inches in men, > 16 inches in women)
- Obesità (i.e. body mass index > 30)
- Frequent unexplained arousals from sleep
- Insomnia (G47.00)

C. Co-morbid Conditions

- Pulmonary hypertension
- Moderate to severe congestive heart failure, documented NYHA Class III or IV
- Moderate to severe pulmonary disease such as chronic obstructive pulmonary disease (COPD)
  as demonstrated on pulmonary function studies
- Moderate to severe neuromuscular/neurodegenerative disorder causing restrictive lung diseases (e.g., kyphoscoliosis, myasthenia gravis, amyotrophic lateral sclerosis (ALS), post-polio syndrome, polymyositis, Guillian Barre syndrome)
- Obesity hypoventilation syndrome
- Chronic opioid medication use

D. Epworth Sleepiness Score (ESS):

What is the member’s Epworth sleepiness score? ____________

(Please see ESS on page 3 for reference if needed)

E. Repeat Sleep Study:

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, with what sleep disorders was the patient previously diagnosed? ____________________________

(Submit previous sleep study)

Repeat study indication: Change in BMI >10% ______ Recent T/A or UPPP ______ Other ______
Compliance for repeat studies: PAP used > 2 mos. Yes ______ No ______ 70% of usage 4+ hours per 24 hour period? Yes ____ No __

(Submit PAP compliance report)

III. Rendering Facility/Qualified Healthcare Professional

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. ICD-10 Diagnosis Code(s): 1) __________ 2) __________ 3) __________ 4) __________

PHYSICIAN or QUALIFIED HEALTHCARE PROFESSIONAL’S SIGNATURE

X __________

Type/print name and date

X __________

No signature stamps allowed.
By signing this request, the physician or qualified healthcare professional verifies that the information reported is true and accurate.
**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</th>
<th>Chance of Dozing or Sleeping</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
<td>Lying down to rest in the afternoon</td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
<td>Sitting and talking to someone</td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td></td>
<td>Sitting quietly after lunch (without alcohol)</td>
</tr>
<tr>
<td>Being a passenger in a car for an hour without a break</td>
<td></td>
<td>Sitting for a few minutes in traffic while driving</td>
</tr>
</tbody>
</table>

**Total Score equals your ESS** (0 - 9 Average score, normal population)