Sleep Study Prior Authorization Request Form

Phone: 866-827-2469 FAX: 866-536-3618

Portal: www.sleepsms.com or www.carecentrixportal.com

For prior authorization requests, visit www.sleepsms.com or www.carecentrixportal.com to submit online or fax the following:

☐ **Entire completed form** ☐ **Medication list** ☐ **Updated clinical notes**

Insurance Plan:		**Patient Subscriber ID#:**		**Diagnosis Code:**	
Patient First Name:		**Last Name:**		**DOB:**	
Patient Address:		**City:**		**State/**	
Patient Phone:		**Height:**		**Weight:**	**BMI:**
Ordering Physician Name:		**Physician NPI: (Required)**			
Ordering Physician Address:		**City:**		**State/Zip:**	
Physician Phone #:	**( )**	**Physician Fax #:**		**( )**	

I. Study Requested (code definitions are on page 3):

Unattended Home Sleep Test (HST): _____G0399

Facility diagnostic sleep test: _____95810 _____95805 ____95811(full night) ____95811 (split night)
Pediatric < 6 years old _____95782 ____95783

If a facility based diagnostic test is requested and patient qualifies for a home study, may the home study be substituted?
___Yes ___ No* *If No, please provide reason and select co-morbidity in Section III.B or non OSA suspected sleep disorder in Section III. C. Attach all supportive clinical evidence.

If attended titration study is requested, but patient qualifies for auto positive pressure machine (APAP), may the APAP be substituted? ___Yes ___No *If No, please provide reason and supportive clinical evidence.

Is this a Request for a repeat study? ___Yes* ___ No *If **Yes**, date of last study: _____

Repeat study only: _____Weight change > 10% _____Recent T/A or UPPP _____Other
Has PAP been used > 2 mos. ___Yes ___ No 70% of usage 4+ hours per 24 hour period night:
_____Yes ___ No

II. 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: _____

Patient's HST Delivery Preference: Ship to Home _____ Pick up at the sleep center (if available) _____

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III. Clinical Information – Complete ALL those that apply in sections A through G

A. Signs and Symptoms:

____Disturbed or restless sleep ____Non-restorative sleep ____Frequent unexplained arousals ____Fragmented Sleep

____Excessive daytime sleepiness ____Fatigue ____Habitual snoring ____Witnessed apneas

____Choking or gasping during sleep ____BMI > 30 ____Neck circumference ≥ 17 inches (men) or ≥ 16 inches (women)

Duration of symptoms above: _____ less than one month _____ greater than one month

B. Co-morbid Conditions (Recent supporting office notes required):

____ Moderate to severe pulmonary hypertension, with pulmonary artery pressure greater than 40 mm Hg

____ Acute, uncontrolled cardiac arrhythmia(s) supported by clinical documentation

____ Moderate to severe COPD or asthma, as diagnosed on pulmonary function studies (PFTs)

____ 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 Guillian Barre syndrome

____Chronic opioid medication use

C. 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 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

D. Epworth Sleepiness Score (required to be completed with patient responses):

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 = Would 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

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

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E. Current Medications:

____Submitting medication list ____ No prescriptions or OTC medications

Check here if patient is taking any medications in these categories: ____ SSRI ____ Pain controlling or sedating

F. Special Needs:

Occupational or social limitations (specify): _____

Is an alternate language spoken (specify): _____

G. Additional Notes:

IV. Reference Table of Codes and Descriptions

Code	Description
G0399	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
95806	Home sleep test (HST), simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort
95808	Polysomnography; any age, sleep staging with 1 to 3 additional parameters of sleep, attended by a technologist
95810	Polysomnography; age 18 years or older, sleep staging with 4 or more additional ••parameters of sleep, attended by a technologist
95811	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
95811	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)
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95783	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