Sleep Study Precertification Request Form

Phone: 866-827-5861 Fax: 866-536-8046
Portal: www.sleepmanagmentsolutions.com

For sleep service precertification requests, visit www.sleepmanagmentsolutions.com, to submit online or fax the following:

☐ **Entire completed form (2 pages)** ☐ **Medication list** ☐ **Updated clinical notes**

Insurance Plan:	Neighborhood Health Plan	Patient ID#:	
Patient First Name:		Last Name:	
Patient Address:		City:	
State:	Zip::	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 HST: _____G0398 _____ G0399 _____ G0400 _____ 95800 _____ 95801 _____ 95806

Facility diagnostic sleep test: ____ 95807 _____95808 _____ 95810 _____ 95782 ____ 95783 ____ 95805
____ 95811(full night) ____95811 (split night)

If a diagnostic test is requested at a facility and the patient qualifies for HST, can a home study be substituted?
___Yes ___ No* *If No, provide reason and select co-morbidity in Section B and attach supportive clinical evidence.
If attended titration study is requested, but the patient qualifies for an auto-positive pressure machine (APAP), can this be approved as a first step? ___Yes ___ No

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

Repeat study only: _____Change in BMI > 5% _____ Recent T/A or UPP _____ Other
Has PAP been used > 2 mos. ___Yes ___ No
70% of usage 4+ hours per night: ___Yes* ___ No

II. Preferred sleep test provider(s), please list below. Sleep Management Solutions reserves the right to assign a provider.

Sleep Lab (if attended study): Name _____ NPI# _____
Tax ID # _____ Fax (_____) _____-_____ Phone (____) _____-_____
Address _____

HST (if Home Sleep Test): Name _____ NPI# _____
Tax ID # _____ Fax (_____) _____-_____ Phone (____) _____-_____
Address _____
Patient's HST Delivery Preference: Ship to home _____ Pick up at sleep center (if available) _____

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III. Clinical Information – Check all that apply

Symptoms of sleep disordered breathing (For repeat studies, complete A, B, and C for new onset symptoms):

A. Complaint(s):

___ Disruptive snoring ___ Witnessed apnea events ___ Choking or gasping during sleep ___ Insomnia

___ Excessive daytime sleepiness ___ Insomnia ___ Nocturia ___ Hypertension

___ Disturbed or restless sleep ___ Non-restorative sleep ___ Frequent unexplained arousals

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

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

____ Unexplained pulmonary hypertension ____ Uncontrolled significant, persistent cardiac arrhythmia

____ Moderate to severe pulmonary disease ____ Neuromuscular weakness preventing HST

____ Uncontrolled CHF (Class III or IV) ____ Neurodegenerative disorders/cognitive impairment preventing HST

C. Suspected Other Sleep Disorders:

____ Suspected Other Sleep Disorders (Non-OSA Diagnosis) ____ Suspected Central Apneas or Complex Sleep Apnea

____ Suspected Narcolepsy (please describe symptoms present) ____ Suspected REM disorder

____ Suspected Nocturnal Seizures ____ Suspected Periodic Limb Movement Disorder (PLMD)

D. Special Needs:

Occupational or social limitations (specify) _____

Is an alternate language spoken (specify) _____

E. Current Medications: ____ Submitting mediation list ____ No prescriptions or OTC medications

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

F. 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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Reference Table of Codes and Descriptions

Code	Description
G0398	Home sleep test (HST) with type ii portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
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
G0400	Home sleep test (HST) with type iv portable monitor, unattended; minimum of 3 channels
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time
95801	Home sleep test (HST), simultaneous recording: heart rate, oxygen saturation, respiratory analysis and sleep time
95806	Home sleep test (HST), simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist
95808	Polysomnography, any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
95811	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 bi-level ventilation, attended by a technologist
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
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness