

# SLEEP TESTING *oneForm* REQUEST

Submit Page 1 & 2 with most recent office notes and supporting documentation  
Fax to 617.796.9099

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ English Proficient: YES NO Language: \_\_\_\_\_

Patient Phone Numbers: Home (\_\_\_\_) \_\_\_\_\_ Alternate (\_\_\_\_) \_\_\_\_\_

Height \_\_\_\_ Weight \_\_\_\_ BMI \_\_\_\_ Epworth Scale Score \_\_\_\_ INSURANCE ID #: \_\_\_\_\_

- |   |                                 |                                      |   |
|---|---------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Aetna *          | <input type="checkbox"/> Cigna  | <input type="checkbox"/> Tufts       | <input type="checkbox"/> Medicare                       |
| <input type="checkbox"/> BCBS             | <input type="checkbox"/> Fallon | <input type="checkbox"/> United      | <input type="checkbox"/> Medicaid                       |
| <input type="checkbox"/> BCBS PPO/Federal | <input type="checkbox"/> HPHC   | <input type="checkbox"/> Unicare/GIC | <input type="checkbox"/> Masshealth-PCP Referral# _____ |
| <input type="checkbox"/> BMC              | <input type="checkbox"/> NHP    | <input type="checkbox"/> Other:      | *payor specific precertification form required          |

## Sleep Study Procedure Requested

- Split Night Study** 95811 Diagnostic testing including CPAP initiation and titration if appropriate criteria met. If criteria is met with less than three testing hours remaining, a new order will be required for an all-night PAP titration study. Refer to interpretation report.

**If the in-lab study is not approved and a home sleep test is offered, I authorize the HST as a substitution unless "NO" is selected**  NO

- PAP Titration** 95811 Titrate positive airway pressure to optimal pressure level  
 CPAP  Bi-Level PAP\*  ASV\* \*CPAP must be previously proven ineffective

- Home Sleep Test (HST) G0399** Provider: Neurocare, Inc. (TIN: 043032581)

### Special Instructions:

#### Special Needs or Accommodations:

- Supplemental Oxygen

#### Preferred DME Supplier:



Initiate home CPAP therapy script for independent, participating DME vendor, coordinated by an LGH Sleep Specialist following diagnostic study demonstrating medical necessity, utilizing an auto titrating device with heated humidifier. **A consultation with a Lawrence General Hospital Sleep Center sleep specialist will be scheduled following testing to review results and manage CPAP.**

- CPAP Management**

## Indication (Suspected Sleep Disorder):

- |  |   |                                 |
|--|---|---------------------------------|
| <input type="checkbox"/> Unspecified Sleep Apnea Symptoms (780.57/ G47.30) | <input type="checkbox"/> Narcolepsy (347.00/ G47.419)             | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Obstructive Sleep Apnea (327.23/G47.33)           | <input type="checkbox"/> Periodic Limb Movements (327.51/ G47.61) |                                 |
| <input type="checkbox"/> Central Apnea (327.21/ G47.31)                    | <input type="checkbox"/> REM Behavior Disorder (327.42/ G47.52)   |                                 |

## A. Patient Complaints : Select at least one

- |   |  |
|---|--|
| <input type="checkbox"/> Excessive daytime sleepiness                           | <input type="checkbox"/> Frequent arousals/disturbed or restless sleep |
| <input type="checkbox"/> Disruptive snoring                                     | <input type="checkbox"/> Not refreshed or rested after sleeping        |
| <input type="checkbox"/> Irregular breathing / pauses in breathing during sleep | <input type="checkbox"/> Inability to fall asleep/remain asleep        |

## B. Symptoms: Select at least two

► Provide supporting office notes

### \*Duration of symptoms:

- |                                     |                                     |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> < 2 months | <input type="checkbox"/> > 6 Months |
| <input type="checkbox"/> > 2 Months | <input type="checkbox"/> > 1 year   |

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Wake up gasping or choking  | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Leg/arm jerking                  |
| <input type="checkbox"/> Morning headaches   | <input type="checkbox"/> Irritability            | <input type="checkbox"/> Injurious behaviors during sleep |
| <input type="checkbox"/> Bruxism/Teeth grinding during sleep                                 | <input type="checkbox"/> Decreased concentration | <input type="checkbox"/> Night Terrors                    |
| <input type="checkbox"/> Witnessed apneas  | <input type="checkbox"/> Memory loss             | <input type="checkbox"/> Sleepwalking                     |
| <input type="checkbox"/> Decreased libido  | <input type="checkbox"/> Hallucinations          | <input type="checkbox"/> Nocturia                         |
| <input type="checkbox"/> Enlarged tonsils/physiologic abnormalities compromising respiration | <input type="checkbox"/> Cataplexy               | <input type="checkbox"/> Other:                           |

**C. Documented Comorbidities Generally Supporting Medical Necessity for In-Lab Testing**

► *Supporting office notes must be provided for precertification submission (criteria varies by payor)*

- Interpretation results indicate O2 desaturations requiring in-lab titration
- History of Myocardial Infarction (s/p 3 months)
- Negative or inconclusive Home Sleep Test (despite high likelihood of OSA)
- History of Stroke Date: \_\_\_\_\_
- Developmentally and functionally incapable of following instructions
- Suspicion of Nocturnal Seizures
- Critical illnesses or physical impairments, which prevent the use of portable monitoring equipment for a home sleep study
- Neuromuscular weakness affecting respiratory function or impairing activities (specify): \_\_\_\_\_
- Appropriate environment for Home Sleep Test unavailable
- Moderate or severe pulmonary disease such as COPD or Cystic Fibrosis (CO2≥45mmHG and O2≤ 88% for ≥5 min @ rest)
- Complex Sleep Behaviors, not recalled by the patient, but suspicious of REMB sleep Behavior Disorder
- Symptomatic lung disease not controlled by medical therapy
- Suspected Narcolepsy
- Documented Obesity Hypoventilation Syndrome
- Cataplexy
- HC03≥.29 (serum bicarb level)
- History of Central or mixed sleep apnea (Must be shown in a previous study)
- Polycythemia (Hg>18.5g/dL male, >16.5g/dL female)
- Moderate to severe congestive heart failure (Class III or Class IV NYHA congestive heart failure)
- Patient prescribed Opiates:
- Tachycardia or bradycardia not controlled by medication
- Patient prescribed SSRI's:
- Unexplained Hypertension (Mean PA pressure>25mmHG at rest; cardiac, vascular, thrombotic causes and pulmonary disease ruled out)
- Other:

**D. HAS THE PATIENT HAS HAD PREVIOUS SLEEP TESTING?  Yes  No**

► *Previous Sleep Study Report must be submitted if available*

**If YES, answer the following questions:**

1. Is the previous diagnostic study unavailable and therefore patient needs **new** documentation of diagnosis?  **Yes**  **No**
2. Did the previous sleep study give a diagnosis of sleep apnea?  **Yes**  **No** or  **Inconclusive**
3. If test was an HST, was the test repeated and inadequate?  **Yes**  **No**
4. Is the reason for retesting due to persistent snoring or other signs and symptoms related to the sleep disorder?  **Yes**  **No**
5. Was the patient started on treatment and now requires follow up testing to assess its effectiveness?  **Yes**  **No**  
 ➤ If yes, which treatment type:  **CPAP**  **BIPAP**  **ASV**  **APAP**  **Dental Appliance**  **Medication**  **Surgery**

**If patient was started on CPAP/BIPAP/ASV/APAP Therapy:**

- a) Have they been wearing for more than 2 months?  **Yes**  **No**  **Not Applicable**
- b) Has the DME provided a mask refit or new mask and education to assist with compliance issues?  **Yes**  **No**
- c) Is retesting requested due to patient's continued symptoms even though they are tolerating wearing CPAP, their compliance download shows AHI<5 and patient is wearing mask 4+hrs on 70% of the nights?  **Yes**  **No**
- d) Is retesting requested due to patient's inability to wear mask successfully?  **Yes**  **No**

I acknowledge that the clinical information submitted to support this request is accurate and specific to this patient, and all information has been provided. I authorize submission of this information for precertification on my behalf.

Ordering Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ NPI \_\_\_\_\_

## Epworth Sleepiness Scale

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

1 = **slight** chance of dozing

2 = **moderate** chance of dozing

3 = **high** chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking with someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
<b>Total</b>	

### Score Analysis

- Score of 1-6: you're getting enough sleep
- Score of 4-8: you tend to be sleepy during the day; this is the average score
- **Score of 9-15: you are very sleepy and should seek medical advice**
- **Score of 16 or greater: you are dangerously sleepy and should seek medical advice**