PRIOR AUTHORIZATION for SLEEP TESTING

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Height:	Weight:	BMI:	Epworth Sleepiness Scale (ESS) Score (0 - 24):	STOP-Bang Score (0 - 8):

Section II: PROVIDER(S) INFORMATION

Ordering Provider:	*Ordering* Provider Address:

Provider NPI #:	Provider TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Rendering Provider:	*Rendering* Provider Address:

Provider NPI #:	Provider TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Facility/Hospital Name:	*Facility/Hospital* Address:

Facility NPI #:	Facility TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Section III: PRE-AUTHORIZATION REQUEST

A. Nature of Request: *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth

B. Requested Date(s) of Service:
From: To:

C. CPT Code (s) Requested:

D. Primary Diagnosis/ICD-10 Code(s):

E. Secondary Diagnosis/ICD-10 Code(s):

F. Will services be billed through a hospital?
☐ No ☐ Yes

G. Sleep Study Place of Service: *Please check.*
☐ Clinic/Sleep Lab ☐ Home ☐ Hospital

H. Sleep Study Monitoring: *Please check.*
☐ Attended ☐ Unattended

I. Will this be an initial or repeat study? *Please check.*
☐ Baseline/Diagnostic/Initial ☐ Repeat

J. Type of Sleep Study/Polysomnography (PSG) being Requested: *Please check all that apply.*

1. ☐ Attended ASV Titration
2. ☐ Attended BiPAP Titration
3. ☐ Attended CPAP Titration
4. ☐ Attended Split-Night
5. ☐ Daytime Nap
6. ☐ Home AutoPAP Titration
7. ☐ Home MSLT/MWT
8. ☐ Home Sleep Apnea Testing (HSAT)
9. ☐ Maintenance of Wakefulness Test/MWT
10. ☐ Multiple Sleep Latency Test/MSLT
11. ☐ Single Nap Study instead of Full MSLT/MWT
12. ☐ Video-EEG-NPSG

(Please check service being requested.) QUESTIONS	YES	NO	COMMENTS/NOTES
K. Is the patient under the age of 18?	☐	☐	
L. Does the patient have any of the following co-morbid medical conditions? *Please check all that apply.* ☐ Amyotrophic Lateral Sclerosis ☐ Chronic Opiate Use ☐ Epilepsy (Seizures) ☐ Guillain Barre Syndrome ☐ Left Ventricular Ejection Fraction < 45% ☐ Moderate to Severe Asthma or COPD ☐ Moderate to Severe Heart Failure (NYHA Class III-IV) ☐ Myasthenia Gravis ☐ Muscular Dystrophy ☐ Myotonic Dystrophy ☐ Obesity Ventilation Syndrome ☐ Parkinson's Disease ☐ Polymyositis ☐ Post-Polio Syndrome ☐ Pulmonary Hypertension ☐ Severe Kyphoscoliosis ☐ Spina Bifida ☐ Severe Obesity (BMI > 45) ☐ Stroke or Other Brain Injury with Residual Neurological or Respiratory Effects ☐ Upper Airway Resistance Syndrome	☐	☐	
M. Does the patient have any of the following co-morbid sleep conditions? *Please check all that apply.* ☐ Central Sleep Apnea (CSA) ☐ Complex/Mixed Sleep Apnea ☐ Complex Parasomnias ☐ Narcolepsy ☐ Narcolepsy Related Symptoms ☐ Nocturnal Seizures ☐ Periodic Limb Movement Disorder ☐ Severe Insomnia ☐ Treatment Emergent CSA	☐	☐	
N. Did the patient have a low baseline nocturnal oxygen saturation (at or under 88% for 15 minutes or more) during an overnight oximetry study, HSAT, diagnostic attended PSG, or the diagnostic phase in a split-night PSG?	☐	☐	*Please submit copy of report.*
O. ☐ **Initial, Repeat, and Split-Night Attended Nocturnal Polysomnography (NPSG):** ***Completion of questions K. - N. required.***			
1. Does the patient have symptoms suggestive of sleep apnea?	☐	☐	
2. Does the patient have a low pretest probability of obstructive sleep apnea (OSA) (STOP-Bang score of less than 3)?	☐	☐	
3. Was an unattended home sleep apnea study (HSAT) negative, indeterminate, or technically inadequate to establish a diagnosis of OSA and the patient has a high pretest probability of OSA?	☐	☐	*Please submit copy of HSAT report.*
4. Does the patient lack the cognitive and physical ability to safely use portable monitoring equipment for a HSAT?	☐	☐	
5. Is initial or repeat NPSG being done for any of the following indications? *Please check.* ☐ Assess treatment response after initial oral airway therapy (OAT) using a custom oral sleep appliance ☐ Assess treatment response after upper airway surgical modification ☐ Confirm diagnosis of OSA prior to surgical modifications of the upper airway ☐ Determine if PAP therapy is still necessary	☐	☐	

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(Please check service being requested.) QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
6. Is repeat attended NPSG being done to determine if PAP therapy is still effective or necessary for any of the following indications? *Please check all that apply.* ☐ Change in medical history (e.g., stroke or other brain injury, heart attack, heart failure) ☐ Substantial weight loss (10% or more of body weight) ☐ New or persistent sleep related symptoms with AHI < 5 on PAP therapy despite adherence (>4 hours per night on 70% of nights for 30 consecutive days)	☐	☐	
P. ☐ Initial and Repeat Attended Full Night PAP Titration Study: ***Completion of questions K. - N. required.***			
1. Has the patient been previously diagnosed with severe sleep apnea?	☐	☐	
2. Is the patient not appropriate for home titration using an auto-titrating PAP device (APAP or auto BiPAP)?	☐	☐	
3. Was the Apnea Hypopnea Index (AHI) ≤ 15 in the first 2 hours of sleep during the first half of an initial diagnostic attended nocturnal sleep study (NPSG/nocturnal polysomnography) or split-night PSG?	☐	☐	*Please submit copy of report.*
4. Is attended full night PAP titration being done because the majority of obstructive respiratory events were not eliminated during the positive airway pressure (PAP) portion of an attended split-night PSG?	☐	☐	
5. Is attended PAP titration study being done because the patient has failed an APAP trial at home?	☐	☐	
5.a. If, yes, does the patient have a residual AHI ≥ 5 while on APAP despite adherence to PAP therapy (>4 hours per night on 70% of nights for 30 consecutive days)?	☐	☐	
5.b. If, yes, does the patient have residual symptoms of excessive daytime sleepiness despite adherence to therapy?	☐	☐	
5.c. If, yes, is the patient not a candidate for auto BiPAP *or* auto BiPAP therapy was tried but was not effective?	☐	☐	
5.d. If, yes, was the patient unable to tolerate PAP therapy during a 1-month minimum trial of APAP and the patient hasn't had a prior PAP attended titration study?	☐	☐	
6. Is repeat attended PAP titration study being done to determine if PAP settings need to be adjusted for any of the following indications? *Please check all that apply.* ☐ Change in medical history (e.g., stroke or other brain injury, heart attack, heart failure) ☐ 10% change in body weight that has resulted in recurrent sleep apnea related symptoms ☐ New or persistent sleep related symptoms with AHI < 5 on PAP therapy despite PAP therapy adherence ☐ Persistent elevation in AHI per PAP device despite PAP adherence ☐ Upper airway surgery has resulted in recurrent sleep apnea related symptoms	☐	☐	
Q. ☐ Video-EEG-NPSG (Nocturnal PSG with Video Monitoring of Body Positions and Extended EEG Channels):			
1. Is test being done to assist with the diagnosis of paroxysmal arousals or other sleep disruptions that are thought to be seizure related when the initial clinical evaluation and results of a standard EEG are inconclusive?	☐	☐	
R. ☐ Initial Multiple Sleep Latency Testing (MSLT) / Maintenance of Wakefulness Test (MWT):			
1. Is testing being ordered for evaluation of symptoms of narcolepsy to confirm the diagnosis?	☐	☐	
1.a. If, yes, does the patient have any of the following symptoms or complaints suggestive of narcolepsy? *Please check all that apply.* ☐ Cataplexy ☐ Hypnagogic Hallucinations ☐ Nighttime Sleep Disruption ☐ Excessive Daytime Sleepiness ☐ Hypnopompic Hallucinations ☐ Sleep Paralysis	☐	☐	
2. Is testing being ordered to help differentiate idiopathic hypersomnia from narcolepsy because the patient has suspected idiopathic hypersomnia?	☐	☐	
3. Is testing being ordered for any of the following conditions or indications? *Please check all that apply.* ☐ Attention Deficit Hyperactivity Disorder ☐ Circadian Rhythm Disorder ☐ Obstructive Sleep Apnea ☐ Chronic Fatigue Syndrome ☐ Evaluate modafinil effectiveness in narcolepsy ☐ Psychiatric Hypersomnolence ☐ Insomnia ☐ Restless Leg Syndrome	☐	☐	
4. Is testing being ordered for evaluation of common, uncomplicated, or non-injurious parasomnias, such as typical disorders of arousal, bruxism, enuresis, nightmares, or sleep talking?	☐	☐	
5. Is testing being ordered for a neurologic disorder other than narcolepsy (e.g., dementia [Alzheimer's disease and dementia with Lewy bodies], Parkinson's Disease)?	☐	☐	
S. ☐ Repeat Multiple Sleep Latency Testing (MSLT) / Maintenance of Wakefulness Test (MWT):			
1. Is repeat testing being ordered because initial testing was invalid or uninterpretable?	☐	☐	*Please submit copy of previous MSLT/MWT.*
2. Is repeat testing being ordered because extraneous circumstances affected the initial test?	☐	☐	
3. Is repeat testing being ordered because study conditions were not present during the initial testing?	☐	☐	
4. Is repeat testing being ordered because narcolepsy is suspected but earlier MSLT or MWT evaluation did not provide polygraphic confirmation?	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.