PEHP Health & Benefits

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 Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

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

Height:	Weight:	BMI:	Neck Circumference:	Mallampati Score:	Epworth Sleepiness Scale (ESS) Score (*0-24):*

Section II: PROVIDER INFORMATION

Date Requested:	Ordering Provider/Physician:	Ordering Provider/Physician NPI #:

Ordering Provider/Physician Contact Person:	Phone: ( )	Facsimile: ( )

Rendering Provider/Physician:	Rendering Provider/Physician NPI #:	Rendering Provider/Physician Contact Person:	Rendering Provider/Physician Phone: ( )

Facility Name:	Facility NPI #:	Facility Tax ID #:	Facility Address:

Facility Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Date (s) of Service:	CPT Code (s):	Will services be billed through a hospital?
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent			☐ No ☐ Yes

Medical Diagnosis/ICD-10 Code (s):	Treating Diagnosis/ICD-10 Code (s):

A. Sleep Study Place of Service: *Please check.*
☐ Clinic/Office ☐ Home ☐ Hospital

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

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

D. Type of Sleep Study/Polysomnography (PSG) being Requested: *Please check.*
1. ☐ Attended ASV Titration 2. ☐ Attended BiPAP Titration 3. ☐ Attended CPAP Titration 4. ☐ Attended Split-Night 5. ☐ Daytime Nap
6. ☐ Home Unattended AutoPAP Titration 7. ☐ Home Unattended Baseline 8. ☐ Maintenance of Wakefulness Test/MWT 9. ☐ Multiple Sleep Latency Test/MSLT

(Please check service being requested.) **QUESTION**	YES	NO	COMMENTS/NOTES
E. ☐ **Home Sleep Study**	☐	☐	*If "YES", stop. Do not go further.*
F. ☐ **Hospital or Clinic/Office Based Attended Sleep Testing (Diagnostic):**			
1. Does the patient have an inability to lay flat and/or lacks mobility or dexterity for a home sleep study?	☐	☐	
2. Does the patient have any of the following co-morbid medical conditions? *Please check all that apply.* ☐ Amyotrophic Lateral Sclerosis ☐ CHF Class III or IV ☐ Chronic Opiate Use ☐ Epilepsy (Seizures) ☐ LVEF < 45% ☐ Moderate-Severe Asthma ☐ Parkinson's Disease ☐ Moderate-Severe COPD ☐ Myotonic Dystrophy ☐ Severe Insomnia ☐ Spina Bifida ☐ Stroke (CVA) ☐ Upper Airway Resistance Syndrome ☐ Other Neuromuscular Disease: _____	☐	☐	
3. Does the patient have any of the following co-morbid sleep conditions? *Please check all that apply.* ☐ Central Sleep Apnea ☐ Chronic Opioid Medication ☐ Complex Sleep Apnea ☐ Narcolepsy ☐ Parasomnias ☐ Severe Insomnia	☐	☐	
4. Did the patient have a facility-based sleep study previously? Date: _____ AHI during the first 2 hours of study: _____	☐	☐	*Please submit copy of report.*
5. If previous sleep study was a split-night study were the vast majority of obstructive respiratory events abolished with the use of CPAP?	☐	☐	*Please submit copy of report.*
6. Did the patient have a home sleep study previously? Date: _____ Sleep conditions diagnosed: _____	☐	☐	*Please submit copy of report.*
7. Was the home sleep study (portable monitoring) result negative or technically inadequate?	☐	☐	*Please submit copy of report.*
8. Was the patient prescribed CPAP therapy previously? Date: _____ AHI while on CPAP: _____ CPAP compliance percentage: _____	☐	☐	
9. Does the patient have persistent obstructive symptoms despite use and compliance with CPAP therapy?	☐	☐	
10. Is study being done to confirm diagnosis of obstructive sleep apnea prior to surgical modifications of the upper airway?	☐	☐	

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

(Please check service being requested.) **QUESTION (*cont'd*)**	YES	NO	COMMENTS/NOTES
G. ☐ **Hospital or Clinic/Office Based Attended CPAP Titration:**			
1. Has the patient been diagnosed with central sleep apnea by NPSG (Nocturnal Polysomnography)?	☐	☐	*Please submit copy of report.*
2. Does the patient have severe pulmonary disease such as COPD or severe asthma?	☐	☐	
3. Does the patient have congestive heart failure (NYHA class III or IV or LVEF less than 45%)?	☐	☐	
4. Is the patient's BMI greater than 45?	☐	☐	
5. Does the patient have chronic opioid use (for example, over 12 mos. of daily use)?	☐	☐	
6. Does the patient have a neuromuscular disease that affects respiration?	☐	☐	
7. Does the patient have a low baseline nocturnal oxygen saturation (at or under 88% for ≥ 15 minutes)?	☐	☐	
H. ☐ **Repeat Hospital or Clinic/Office Based Attended Sleep Testing:** *Please check*			
1. Is repeat testing being ordered for any of the following indications?			
☐ Determine if positive airway pressure treatment continues to be effective for patient with new or persistent symptoms after interrogation of current positive airway pressure device.			
☐ Determine if positive airway pressure treatment settings need to be changed for patient with new or persistent symptoms after interrogation of current positive airway pressure device.	☐	☐	
☐ Determine whether continued treatment with positive airway pressure therapy is needed after patient has had substantial weight loss (loss of 10% or more body weight) or some other change in their medical condition (e.g., heart attack, stroke, heart failure).			
☐ Determine whether continued treatment with positive airway pressure treatment is necessary.			
☐ To assess treatment response after upper airway surgical procedures or oral appliances.			
I. ☐ **Multiple Sleep Latency Testing (MSLT) / Maintenance of Wakefulness Test (MWT):**			
1. Is request for a single nap study instead of a full MSLT or MWT?	☐	☐	
2. Is request for a home MSLT instead of a formal MSLT performed in a sleep laboratory?	☐	☐	
3. Is testing being ordered for Attention Deficit/Hyperactivity Disorder?	☐	☐	
4. Is testing being ordered for Chronic Fatigue Syndrome?	☐	☐	
5. Is testing being ordered for Circadian Rhythm Disorder?	☐	☐	
6. Is testing being ordered for evaluation of effectiveness of modafinil therapy in narcolepsy?	☐	☐	
7. 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?	☐	☐	
8. Is testing being ordered to evaluate symptoms of narcolepsy and to confirm the diagnosis?	☐	☐	
9. Is testing being ordered for insomnia?	☐	☐	
10. Is testing being ordered for Obstructive Sleep Apnea?	☐	☐	
11. Is testing being ordered for a neurologic disorder other than narcolepsy (e.g. dementia, including Alzheimer's disease and dementia with Lewy bodies, and Parkinson's Disease)?	☐	☐	
12. Is testing being ordered for Psychiatric Hypersomnolence?	☐	☐	
13. Is testing being ordered for Restless Leg Syndrome?	☐	☐	
14. Is testing being ordered to help differentiate idiopathic hypersomnia from narcolepsy because the patient has suspected idiopathic hypersomnia?	☐	☐	
14. a. Does the patient have any of the following symptoms or complaints suggestive of narcolepsy? *Please check all that apply.*			
☐ Cataplexy (Sudden loss of muscle control with retention of clear consciousness.			
☐ Excessive Daytime Sleepiness (An uncontrollable urge to sleep, often at inappropriate times)			
☐ Hypnagogic or Hypnopompic Hallucinations (Visual, tactile, auditory, or other sensory events, usually brief but occasionally prolonged, that occur at the transition from wakefulness to sleep [hypnagogic] or from sleep to wakefulness [hypnopompic].)	☐	☐	
☐ Nighttime Sleep Disruption (Inability to maintain sleep for more than a few hours at a time.)			
☐ Sleep Paralysis (Feeling unable to move or speak when falling asleep or waking up.)			
J. ☐ **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 report.*
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:			

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