Lawrence General Hospital

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 #:_____

☐ Aetna *	☐ Cigna	☐ Tufts	☐ Medicare
☐ BCBS	☐ Fallon	☐ United	☐ Medicaid
☐ BCBS PPO/Federal	☐ HPHC	☐ Unicare/GIC	☐ Masshealth-PCP Referral# _____
☐ BMC	☐ NHP	☐ 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 Attended In-Lab study is denied by insurance, a Home Sleep Test may be substituted if approved ☐ YES ☐ 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) G3099** Provider: Neurocare, Inc. (TIN: 043032581)

Special Needs or Accommodations:
☐ Supplemental Oxygen

Special Instructions:

Preferred DME Supplier:

☐ **CPAP Management** EXPRESSCare Initiate home CPAP therapy through the independent, participating DME vendor coordinated by the Sleep Center at Lawrence General Hospital within 48 hours following diagnostic study demonstrating medical necessity, utilizing an auto titrating device with heated humidifier set to apply pressure from a setting of 6cm H2O to a maximum pressure of 3cm H2O above optimal pressure. Bi-Level PAP and ASV titrations will require a separate script which Neurocare will send to the referring physician for completion the morning following testing. **A consultation with a Lawrence General Hospital Sleep Center sleep specialist will be scheduled *approximately 4 weeks after the sleep study to review results and manage CPAP***

Indication (Suspected Sleep Disorder):

☐ Unspecified Sleep Apnea Symptoms (780.57/ G47.30)
☐ Obstructive Sleep Apnea (327.23/G47.33)
☐ Central Apnea (327.21/ G47.31)
☐ Narcolepsy (347.00/ G47.419)
☐ Periodic Limb Movements (327.51/ G47.61)
☐ REM Behavior Disorder (327.42/ G47.52)
☐ Other:

A. Patient Complaints : Select at least one

☐ Excessive daytime sleepiness
☐ Disruptive snoring
☐ Irregular breathing / pauses in breathing during sleep
☐ Frequent arousals/disturbed or restless sleep
☐ Not refreshed or rested after sleeping
☐ Inability to fall asleep/remain asleep

B. Symptoms: Select at least two

****Duration of symptoms: _____ week (required)***

►*Provide supporting office notes*

☐ Wake up gasping or choking
☐ Morning headaches
☐ Bruxism/Teeth grinding during sleep
☐ Witnessed apneas
☐ Decreased libido
☐ Enlarged tonsils/physiologic abnormalities compromising respiration
☐ Hypertension
☐ Irritability
☐ Decreased concentration
☐ Memory loss
☐ Hallucinations
☐ Cataplexy
☐ Leg/arm jerking
☐ Injurious behaviors during sleep
☐ Night Terrors
☐ Sleepwalking
☐ Nocturia
☐ 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 02 desaturations requiring in-lab titration
- ☐ Negative or inconclusive Home Sleep Test (despite high likelihood of OSA)
- ☐ Developmentally and functionally incapable of following instructions
- ☐ Critical illnesses or physical impairments, which prevent the use of portable monitoring equipment for a home sleep study
- ☐ Appropriate environment for Home Sleep Test unavailable
- ☐ Complex Sleep Behaviors, not recalled by the patient, but suspicious of REMB sleep Behavior Disorder
- ☐ Suspected Narcolepsy
- ☐ Cataplexy
- ☐ History of Central or mixed sleep apnea (Must be shown in a previous study)
- ☐ Moderate to severe congestive heart failure (Class III or Class IV NYHA congestive heart failure)
- ☐ Tachycardia or bradycardia not controlled by medication
- ☐ Unexplained Hypertension (Mean PA pressure>25mmHG at rest; cardiac, vascular, thrombotic causes and pulmonary disease ruled out)
- ☐ History of Myocardial Infarction (s/p 3 months)
- ☐ History of Stroke Date: _____
- ☐ Suspicion of Nocturnal Seizures
- ☐ Neuromuscular weakness affecting respiratory function or impairing activities (specify):_____
- ☐ Moderate or severe pulmonary disease such as COPD or Cystic Fibrosis (CO2≥45mmHG and 02≤ 88% for ≥5 min @ rest)
- ☐ Symptomatic lung disease not controlled by medical therapy
- ☐ Documented Obesity Hypoventilation Syndrome
- ☐ HC03≥.29 (serum bicarb level)
- ☐ Polycythemia (Hg>18.5g/dL male, >16.5g/dL female)
- ☐ Patient prescribed Opiates:
- ☐ Patient prescribed SSRI's:
- ☐ 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	
Total	

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**