

## Review Request for Diagnosis of Sleep Disorders

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 08/28/08		Policy Effective Date: 08/28/08		Provider Tool Effective Date: 8/10/09	
Member Name:			Date of Birth:		
Insurance Identification Number:			Member Phone Number:		
Ordering Provider Name and Specialty:			Provider ID Number:		
Office Address:					
Office Phone Number:			Office Fax Number:		
Rendering Provider Name and Specialty:			Provider ID Number:		
Office Address:					
Office Phone Number:			Office Fax Number:		
Facility Name:			Facility ID Number:		
Facility Address:					
Date/Date Range of Service:			Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient		
Service Requested (CPT if known):			<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____		
Diagnosis (ICD-9) if known:					

**Please check all that apply to the member:**

**Home or Portable Polysomnography**

- Member is an adult
- Member is a child
- Study performed using Type 3 monitoring devices including (check all that apply):
  - Ventilation or airflow (at least 2 channels of respiratory movement or respiratory movement and airflow)
  - Heart rate or ECG
  - Oxygen saturation
  - Other(s) (please list all): \_\_\_\_\_
- Study requested as an alternative to standard polysomnography
- Member has severe clinical symptoms highly suspicious for obstructive sleep apnea, where initiation of treatment is felt to be urgent and standard polysomnography is not readily available
- Member is unable to be studied in a sleep laboratory
- Study is for follow up after the diagnosis has already been established by standard polysomnography and therapy initiated

**Home or Portable Polysomnography (continued)**

- To confirm diagnosis of obstructive sleep apnea in member with a high pretest probability of moderate to severe obstructive sleep apnea based on the presence of the following (please check all that apply)
  - Habitual snoring
  - Epworth sleepiness scale greater than 10
  - Obesity (BMI > 30)
  - Witnessed apnea
- No evidence of a significant medical comorbidity (e.g. CHF, chronic pulmonary disease or neuromuscular disease)
- No suspicion of other sleep disorder (e.g. narcolepsy, central sleep apnea, or periodic limb movement disorder).
- Other: \_\_\_\_\_

**Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing**

- Request is for Multiple Sleep Latency Testing (MSLT)
- Request is for Portable Multiple Sleep Latency Testing in home setting
- Request is for Maintenance of Wakefulness Testing

Test is for any of the following conditions (check all that apply):

- Evaluation of narcolepsy
- Evaluation of suspected idiopathic hypersomnia
- Routine diagnosis of obstructive sleep apnea
- Follow up after treatment of sleep-related disorders
- Evaluation of sleepiness in medical or neurological disorders (other than narcolepsy or idiopathic hypersomnia), including, but not limited to, insomnia, circadian rhythm disorders and Shift Work Sleep disorder (SWSD)
- Other: \_\_\_\_\_

**“NAP” Study**

- Study performed for screening purposes
- Study performed as an alternative to polysomnography for the diagnosis of obstructive sleep apnea or narcolepsy

**Actigraphy and Static Charge Sensitive Bed**

- Study will be performed as the sole method for diagnosis or evaluation of obstructive sleep apnea

**Other**

- Request is for Diagnostic Audio Recording, with or without pulse oximetry, to document sleep apnea
- Request is for Topographic Brain Mapping
- Request is for acoustic pharyngometry (Eccovision™ Acoustic Pharyngometer®)
- Other: \_\_\_\_\_

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: \_\_\_\_\_
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

\_\_\_\_\_  
Name and Title of Provider or Provider Representative  
Completing Form (Please Print)\*

\_\_\_\_\_  
Date

\* **The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**