Neighborhood Health Plan OF RHODE ISLAND™

Sleep Study
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Provider NPI #:	Date Request Sent:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider Contact and Phone #:	Provider's Fax #:	Ordering MD:

CLINICAL INFORMATION

Diagnosis & Diagnosis Code:	**Reason for initial test in a Facility:**
Patient's H/W/BMI	❑ Pediatric/Adolescent
Epworth Sleepiness Score	❑ Cardiac disease (CHF NYHA 3 or 4, uncontrolled arrhythmia, pulmonary hypertension, recent (6months)MI
Comorbid conditions	❑ Chronic Pulmonary disease - COPD req oxygen, obesity hypoventilation, lung disease uncontrolled by medical therapy
Test Requested: CPT CODE:	❑ Neurologic d/o – previous CVA/TIA, nocturnal seizures, Parkinson's, AML, neurodegenerative disorders
❑ Attended full channel nocturnal polysomnography (NPSG)/laboratory sleep test (LST) ❑ Multiple sleep latency testing (MLST) (only for narcolepsy)	**Complex sleep disorder:** ❑ Narcolepsy ❑ Parasomnias ❑ Periodic limb movement disorder ❑ Central sleep apnea
Split night study: CPT CODE	❑ BMI ≥ 50
❑ AHI ≥ 40 in the first 2 hours ❑ CPAP nearly/eliminates respiratory events during non/REM sleep ❑ CPAP titration > 3hours	❑ Previous Home testing inconclusive ❑ Lack of mobility/dexterity ❑ Cognitive impairment ❑ Other
❑ **CPAP titration CPT CODE:**	

Reason for repeat NPSG/LST:

❑ Assess continued need for CPAP	❑ Assess need to change settings for positive airway pressure
❑ Assess because of failed APAP/CPAP or symptom recurrence	❑ Confirm the presence of OSA prior to upper airway surgery
❑ Failed split night NPSG	❑ Other

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Treating Physician:	**Date:**

NEIGHBORHOOD DECISION - Authorization is not a guarantee of payment.

Authorization #:	Dates of Service:	Services Approved:
UM Initials:	**Notification Date:**	❑ **Not Approved - Letter to Follow**