BIPAP - Sleep Study Validation Form – E0471 or E0472

Attn: Utilization Management

Phone: 800-891-2520 Fax: 567-661-0846

(Must include DME Prior Authorization Form)

PATIENT INFORMATION

Member Name _____ Paramount ID# _____

DOB _____ Paramount Secondary ID#:_____

Phone Number _____ (if applicable)

REFERRAL SOURCE

Referral Organization_____ Ordering Physician Name _____

Phone Number _____ Date of Clinical Evaluation_____

Face to Face Clinical Evaluation by Treating Practitioner perform prior to the Sleep Study: *Yes* ☐ *No* ☐

Provider Billing Tax ID (TIN):_____

DIAGNOSIS ICD-10: A specific ICD-10 code must be provided

☐ G47.33 Obstructive Sleep Apnea (OSA) (Adult and Child) ☐ Other _____

☐ Secondary condition _____

HCPCS Code: E0471 (*requires an "Other" primary condition to OSA)* ☐ or E0472 ☐

SLEEP STUDY ATTESTATION

Order Date _____ Sleep Study Performed Date _____

Site of Study _____ Phone Number _____

Fax Number _____

AHI/RDI/REI Result: ≥ 15 ☐ or ≥ 5 and < 15 ☐

OSA for an individual with coexisting hypoventilation: *Yes* ☐ *No* ☐

The member met all CPAP required criteria: Yes ☐ No ☐

Retrial Exception: Yes ☐ No ☐ N/A ☐ Comment: _____

Must meet ALL of the following criteria:

-Diagnostic PSG show 5 or more obstructive respiratory events (Obstructive or Mixed Apneas, Hypopneas, Respiratory efforts related arousals [RERAs per hours of sleep]: Yes ☐ *No* ☐

-PSG during use of PAP without backup rate show significant resolution of obstructive events and emergence or persistence of central apnea or central hypopnea with ALL of the following: Yes ☐ No ☐

Central Apneas and Central Hypopnea ≥ 5 per hour

Number of Central Apneas and Central Hypopneas > 50% of total number of apneas and hypopneas

-Central Sleep Apnea (CSA) is not better explained by another CSA disorder: Yes ☐ No ☐

-Individual does not have symptomatic and/or reduced left ventricular ejection fraction ≤ 45% as determined by Cardia assessment conducted prior to initiation of treatment: Yes ☐ No ☐

-Instructions in the proper use and care of equipment given: Yes ☐ No ☐

-Provider Attests Compliance for Continued PAP Use after 90 days: Yes ☐ No ☐ N/A ☐

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the item(s) prescribed.

Print Provider's or DME Provider Name _____ NPI # _____

Provider's or DME Provider's Signature _____ Date _____