

**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:  $\geq 15$   or  $\geq 5$  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  $\geq 5$  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  $\leq 45\%$  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 \_\_\_\_\_

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