



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Sleep Apnea Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.

Provider Information

Provider Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Patient Information

Patient Name: _____
 ID Number: _____
 Address: _____
 Patient's DOB: _____
 Phone: _____

Ordering Physician Information

Ordering Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Treatment Information

Primary Procedure: _____
 Procedure (ICD-9) Code(s): _____
 Date of Procedure: _____
 Place of Service: _____

Has a polysomnography study been completed? YES NO
 Is the Apnea Hypopnea Index (AHI) or a Respiratory Disturbance Index (RDI) greater than or equal to 15 events per hour? YES NO
 Is the AHI (or RDI) greater than or equal to 5, and less than 15 events per hour with documentation demonstrating **any** of the following symptoms: YES NO

- Excessive daytime sleepiness, as documented by either a score of greater than **10** on the Epworth Sleepiness scale or inappropriate daytime napping, (e.g., during driving, conversation or eating) or sleepiness that interferes with daily activities;
- Impaired cognition or mood disorders
- Hypertension
- Ischemic heart disease or history of stroke
- Cardiac arrhythmias

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Pulmonary hypertension

Other, please specify _____

Will an oral appliance be used? YES NO

Please explain _____

Will the member undergo surgery UPPP? YES NO

If yes please answer below:

Does the patient have Obstructive Sleep Apnea (OSA) YES NO

Is the surgical treatment UPPP a **sole** procedure: with AHI (or RDI) greater than 15 and less than 40, OR AHI/RDI 10-15 with **one or more** of the conditions listed below: YES NO

If yes, please check all conditions that apply below

Hypertension

Cardiac arrhythmias predominately during sleep

Pulmonary hypertension

Documented ischemic heart disease

Impaired cognition or mood disorders

History of stroke

Excessive daytime sleepiness, as documented by either a score of greater than **10** on the Epworth Sleepiness Scale or inappropriate daytime napping, (e.g., during driving, conversation or eating) or sleepiness that interferes with daily activities.

Is the UPPP part of a **planned staged** or **combined** surgery aimed at also relieving retrolingual obstruction, (e.g., genioglossal advancement, hyoid myotomy and suspension): AHI/RDI greater than 15, OR AHI/RDI 10-15

YES NO

If yes, please check conditions below that apply

Hypertension

Cardiac arrhythmias predominately during sleep

Pulmonary hypertension

Documented ischemic heart disease

Impaired cognition or mood disorders

History of stroke

Excessive daytime sleepiness, as documented by either a score of greater than **10** on the Epworth Sleepiness Scale or inappropriate daytime napping, (e.g., during driving, conversation or eating) or sleepiness that interferes with daily activities.

Has CPAP been tried with well-supported follow-up and clearly failed or is not tolerated. YES NO

Please explain _____

Does pre-operative evaluation include fiber optic endoscopy suggest retro-palatal narrowing is the primary source of airway obstruction if UPPP is the **sole** procedure or a **contributing** source of airway obstruction if part of a planned staged or combined surgery aimed at also relieving retro lingual obstruction. YES NO

Please provide any additional clinical information

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Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____

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