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-10) 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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