

Sleep Assessment Record Checklist

Please be prepared to provide the applicable information from the following list when requesting prior authorization for a sleep assessment (either attended/facility-based or unattended/home sleep test):

For Sleep Assessments (either Attended or Unattended), please provide:

- 1. **Medical chart notes** from patient chart related to the requested procedure, including patient's current status and symptoms related to sleep disturbances.
- 2. Relevant patient information including:
 - a. Patient age, height, weight, and BMI.
 - b. Neck circumference
 - c. Craniofacial or upper airway soft tissue abnormalities
- 3. **Contraindications to Home Sleep Test:** Documentation of contraindications to a Home Sleep Test, if any (to support a request for an attended study or confirm that there are no contraindications that would impact a request for an unattended study).
- 4. **Symptom history** (onset, course, new or changing symptoms) including reports of witnessed episodes of apnea, snoring/gasping, morning headaches, daytime sleepiness, lack of alertness, etc.
- 5. **Screening test results or reports from other diagnostic** tests (such as Stopbang score, Epworth Sleepiness Scale, previous Apnea-Hypopnea Index, Modified Mallampati Score, etc.).
 - a. If the requests is for an attended sleep study following a failed Home Sleep Test, include documentation of results and issues.
- 6. **Relevant medical history**: such as hypertension, stroke, congestive heart failure, neuromuscular disease, etc.
- 7. Examination results
- 8. Any other documentation that supports the need for the procedure.

For repeat studies, include:

- 1. Documentation of persistent symptoms.
- 2. Documentation of previous treatments or interventions, when applicable.
- 3. For Obstructive Sleep Apnea, documentation that the patient has been using the prescribed device (CPAP, AutoPAP, etc.) regularly.

To initiate an authorization request, please visit <u>RadMD.com</u> or contact Evolent's call center.