BlueCross BlueShield of North Carolina

Use for Blue Medicare HMO/PPO Plans

Bi-Level Positive Airway Pressure with Backup Rate (BIPAP ST) for Treatment of Breathing Related Sleep Disorders
Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Information		Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		

Please answer questions below

HCPCS code(s) (REQUIRED): _____

Is this request for E0471? ……..…….. ☐ Yes ☐ No (If no, do not use this form.)

If this request is for rental of E0471, please provide the following information:

What is the start date of the rental? _ _/_ _/_ _ _ _

Are symptoms characteristic of sleep-associated hypoventilation, such as daytime hyper somnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc., documented in the member's medical record? ☐ Yes ☐ No

Does the member have one of the four respiratory disorders noted below? ……..…… ☐ Yes ☐ No

Complete <u>one of the following four</u> sections as applicable:

1. **Restrictive Thoracic Disorders:**
   A. Is there documentation in the member's medical record of a neuromuscular disease (for example, amyotrophic lateral sclerosis - ALS) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB)? ……..…… ☐ Yes ☐ No

   B. Is there documentation of one of the following?

      1. An arterial blood gas PaCO2, done while awake and breathing the member's prescribed FIO2, which is ≥ 45mmHg? ……..…… ☐ Yes ☐ No

      2. Sleep oximetry demonstrating oxygen saturation < 88%, > 5 minutes of nocturnal recording time (minimum recording time of 2 hours) done while breathing the member's prescribed FIO2? …… ☐ Yes ☐ No

      3. For a neuromuscular disease (only), either a or b:
         a. Maximal inspiratory pressure < 60cm H2O? ……..…… ☐ Yes ☐ No
         b. Forced vital capacity < 50% predicted? ……..…… ☐ Yes ☐ No

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C. Does Chronic Obstructive Pulmonary Disease (COPD) contribute significantly to the member's pulmonary limitation?..... ☐ Yes ☐ No

2. Severe Chronic Obstructive Pulmonary Disease (COPD):

For members who started an E0471 any time after a period of initial use of an E0470 device:

A. Does the member's arterial blood gas PaCO2, done while awake and breathing the member's prescribed FIO2, shows that the PaCO2 worsens ≥ 7mmHg compared to ABG result performed to qualify the member for the E0470 device?? ..... ☐ Yes ☐ No

B. Does a facility-based PSG demonstrate oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours) while using an E0470 device (that is not caused by obstructive upper airway events – i.e., AHI < 5)? ..... ☐ Yes ☐ No

For members who used an E0470 device x 61 days and now require E0471:

A. Does the member's arterial blood gas PaCO2 done while awake and breathing his/her prescribed FIO2, still remain ≥ 52 mm Hg? ..... ☐ Yes ☐ No

B. Does the member's sleep oximetry, while breathing with the E0470 device, demonstrate oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours)? ..... ☐ Yes ☐ No

C. Was the above oximetry completed while breathing oxygen at 2L/min or the member's prescribed FIO2 (whichever is higher)? ..... ☐ Yes ☐ No

3. Central sleep apnea (CSA) or complex sleep apnea (Comp SA):

A. Prior to initiating therapy, did the member have a monitored, facility-based sleep study which documented the following (i and ii)?

1. The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA)? ..... ☐ Yes ☐ No

2. Significant improvement of the sleep-associated hypoventilation with the use of an E0470 device on the settings that will be prescribed for initial use at home, while breathing the member's prescribed FIO2? ..... ☐ Yes ☐ No

4. Hypoventilation syndrome:

A. Is an E0470 device currently being used? ..... ☐ Yes ☐ No

B. Does the member's spirometry show an FEV1/FVC ≥ 70%. ..... ☐ Yes ☐ No

C. Does the member's arterial blood gas PaCO2, done while awake and breathing his/her prescribed FIO2, show that the PaCO2 worsens ≥ 7mmHg compared to ABG result performed to qualify the member for the E0470 device?..... ☐ Yes ☐ No

D. Did a facility-based PSG or HST demonstrate oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events (i.e. AHI <5) while using and E0470 device? ..... ☐ Yes ☐ No

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If this request is for purchase, please provide the following information:

1. Does documentations in the member's medical record reflect progress of relevant symptoms? ….. ☐ Yes ☐ No
2. Does the compliance chip show the member consistently uses the device at least 4 hours per 24 hours? …… ☐ Yes ☐ No

If no, please provide a copy of the compliance download and medical records for review.

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax 1-336-794-1556
For questions please call Care Management at 1-888-296-9790.

Blue Cross and Blue Shield of North Carolina is an HMO/PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.