

CMS Face to Face Checklist for Sleep Study Approval

Physician Note Requirements

This information *MUST* be contained in your Face to Face visit note.
No Addendums or Telephone Encounters are accepted by CMS.

Epworth Sleepiness Scale (ESS) recorded-Total up the answers below. If the question is N/A place in 0.

Choose the most appropriate response for each situation below	High Chance of Dozing	Moderate Chance of Dozing	Slight Chance of Dozing	Would Never Doze
Sitting and reading	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Watching TV	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
As a passenger in a car for an hour without a break	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Sitting inactive in a public place	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Lying down to rest in the afternoon	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
In a car while stopped for a few minutes	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Sitting quietly after lunch without alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
Sitting and talking with someone	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

BMI (or height and weight)

Neck Circumference- in inches

Medical History

Current Medication List

Minimum of Two Sleep Symptoms (DMEs are suggesting three to make sure patient is not denied treatment) listed below:

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Hypersomnia with suspected sleep apnea G47.30 | <input type="checkbox"/> Snoring R06.83 | <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Excessive Daytime Sleepiness G47.11 | <input type="checkbox"/> Waking with gasping or choking |
| <input type="checkbox"/> Morning Headache | <input type="checkbox"/> Difficulty Falling Asleep F51.12 | <input type="checkbox"/> Difficulty Maintaining Sleep F51.12 | <input type="checkbox"/> Nocturia R35.1 | <input type="checkbox"/> Restless Legs at night G25.81 |
| <input type="checkbox"/> Drowsy Driving | <input type="checkbox"/> Motor Vehicle Accidents due to sleepiness | <input type="checkbox"/> Recurring Nightmares F51.8 | <input type="checkbox"/> Grinding Teeth G47.63 | <input type="checkbox"/> Insomnia F51.01 |
| <input type="checkbox"/> Confusional Arousals from Sleep G47.51 | <input type="checkbox"/> Sleep Terrors F51.4 | <input type="checkbox"/> Sleep Paralysis G47.53 | <input type="checkbox"/> Sleep Walking F51.3 | <input type="checkbox"/> Sleep Talking/ Kicking/ Punching/ Eating G47.5 |
| <input type="checkbox"/> Cataplexy G47.4 | <input type="checkbox"/> Hypnagogic/ Hypnopompic Hallucinations H53.16 | <input type="checkbox"/> Auditory Hallucinations while in bed | <input type="checkbox"/> Sleep Related Hypoxemia G47.36 | <input type="checkbox"/> Decreased mental ability during the day |