

VOLUME 9—NO. 2
SPRING 2002

AASM BULLETIN

THE BULLETIN OF THE AMERICAN ACADEMY OF SLEEP MEDICINE

National Office Relocating to Chicago

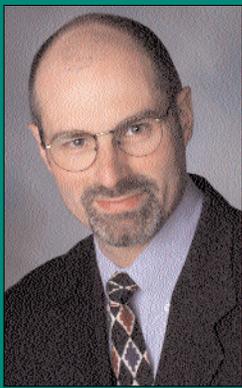
See President's Message

Definitions of "Normal Sleep Quantity and Quality" to be Developed

APSS Annual Meeting Offers the Latest in Sleep Science, Addresses Public Health Issues

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EDITOR'S NOTES

It has been a great pleasure to serve as Editor for the AASM Bulletin during the past year. As I prepare to pass the torch to my successor, John Shepard, M.D., I would like to bring a few items to your attention from within and outside of the covers of this issue.

First, congratulations and thanks are due to the AASM staff and Academy volunteers who work on the APSS meeting and our journal, *SLEEP*. The meeting and journal recently won first place awards in an annual competition sponsored by the American Society of Association Executives. This recognition is a well-deserved indication of the creativity, dedication, hard work, and professionalism of the AASM staff.

Second, a number of articles in this issue point to the continued growth of Sleep Medicine as a medical specialty. For instance, the American Board of Sleep Medicine reports a record number of candidates have applied to take its accreditation examination. The National Sleep Medicine Course will, for the first time, be moving to a larger venue in Dallas, Texas. This move in part results from demand that exceeded available places for the Course in past years. In addition, the AASM is currently planning a new advanced sleep medicine course, which is slated to take place in February 2003. This course is designed to meet the needs of practicing clinicians, and will provide the latest updates in sleep disorder pathophysiology and treatment. We have also seen remarkable growth in the Sleep Medicine Education and Research Foundation. As you will see on page 11, we have had excellent preliminary results from the Foundation's grant awardees. We look forward to their continued success in the future.

Third, I would like to draw your attention to a very interesting article by Tachibana and colleagues on page 26. For the first time, these investigators have estimated the number of sleep laboratories actually operating in the United States, as well as the number of polysomnograms being conducted. The numbers in each case are staggering, but also indicate several future directions for our organization. Mainly, it is important for us all to realize that only a small minority of operating laboratories are accredited. As the vanguard of our field, we need to continue working to demonstrate the added quality and expertise that come with formal training in Sleep Medicine, board certification, and accreditation of laboratories.

Finally, I would like to thank Dr. John Whyte for his comments on the everyday workings of Medicare coverage policies. His article proves that the best route to fair reimbursement and high-quality health care is having accurate information and cooperation between providers, third-party payers, and federal agencies.

These are exciting times to be involved in Sleep Medicine. We are fortunate to see our field in such a strong growth phase. Stay tuned to the AASM Bulletin in the future for updates on our continued progress.

Daniel J. Buysse, M.D.
Editor-In-Chief

IN THIS ISSUE

Spring 2002

VOLUME 9, ISSUE 2

President's Perspective	4-5
Definitions of "Normal Sleep Quantity and Quality" to be Developed	5
History Book on the Discovery of REM Sleep to Be Written	6
Letter from Chris & Fran Gillin	6

COMMITTEE UPDATES

AASM Committee Updates for Spring 2002	8-9
Academy of Dental Sleep Medicine to Hold 11th Annual Conference	9

RELATED ORGANIZATION NEWS

American Board of Sleep Medicine Examinations Foundation to Fund Five Two-Year Grants Each at \$30,000 Per Year	10
National Sleep Awareness Week Held April 1-7, 2002	11

MEMBER BENEFITS

Academy Section Meetings Schedule at APSS Meeting	12
International Affairs Committee to Sponsor Case Studies on International Sleep Centers	12
Take Advantage of the Convenience of the AASM Website	13
American Academy of Sleep Medicine Business Meeting	13
AASM Annual Report to be Released at APSS	13
Academy By-Laws Revision	14
Speakers' Database	14

CME NEWS/EDUCATION

National Sleep Medicine Course Moves to New Location with Increased Capacity	16
Advanced Sleep Medicine Course to be Introduced in February 2003	16



This year's APSS 16th Annual Meeting will be held June 8-13, 2002 in Seattle, Washington

HEALTH POLICY/ GOVERNMENT AFFAIRS

You Have Questions? We Have Answers!	18
News Briefs	19-20, 24

FEATURES

APSS Annual Meeting Offers Latest in Sleep Science, Addresses Public Health Issues	21
A Quantitative Assessment of Sleep Laboratory Activity in the United States	26-28

ADDITIONAL NEWS

New AASM Accredited Sleep Disorder Centers and Laboratories	29
Viewpoint	30-31
Accreditation Briefs	40

CLASSIFIEDS

Calendar of Events, Positions Available, Sleep Fellowships, Announcements	42
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PRESIDENT'S PERSPECTIVE

By John W. Shepard, Jr., M.D., AASM President

What a Year it Has Been!

As my year of service as your President draws to a close, I am amazed at all that has been accomplished by our vibrant proactive organization. Membership increases, government recognizes hypopneas, ACGME receives sleep fellowship application, strategic plan completed, bylaws revised and Unity council created.

CHICAGO HERE WE COME.

In case you haven't heard, the Board of Directors granted final approval to relocate the AASM office to Chicago, Illinois at its March 2002 meeting. Although this is a bittersweet decision for myself and the excellent staff who work and live in Rochester, Minnesota, the Board unanimously felt the move was in the long-term best interest of the organization. The Board has discussed re-location as an issue for many years but action wasn't taken until two years ago when a consultant was hired to provide us with information that would assist us in making this decision. Washington, DC and Chicago were selected as the best cities to meet our future needs. An analysis was then performed to compare their relative strengths and weaknesses along with the option of staying in Rochester.

In July 2001, the Board selected Chicago as the preferred location and authorized our Executive Director, Mr. Jerome Barrett to begin a search for suitable properties in the Chicago area convenient to O'Hare airport. A comparison of multiple properties was presented at the November 2001 Board meeting. In February of this year, Dr. Buysee, Mr. Barrett and myself were able to site visit several of these properties. We have selected a high quality corporate building with a panoramic view of the Chicago skyline and hope that many of our

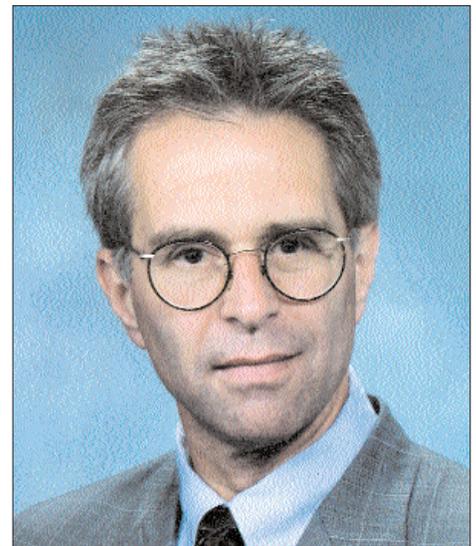
current outstanding staff will be able to continue with us at our new location.

On behalf of the field of sleep medicine, the AASM Board of Directors and staff have completed an application to the Accreditation Council on Graduate Medical Education (ACGME) requesting the establishment of a Residency Review Committee to create nationally recognized one year fellowship training programs in sleep medicine. This has been a tremendous effort on the part of your Board of Directors and AASM staff. Dr. Barbara Phillips accepted the leadership role in this effort and held everyone's feet to the fire to complete drafts of their assigned sections prior to the March 2002 Board meeting where we devoted an entire day to critiquing, organizing and revising the document. Dr. Steve Sheldon's contribution on the structure of the sleep medicine curriculum is especially outstanding. In addition, the application summarizes the major advances in sleep science and circadian rhythms that have provided the new concepts and knowledge on which our new specialty of sleep medicine is based.

Overall, the document is truly impressive and should present a favorable case for the establishment of ACGME accredited fellowships in sleep medicine.

At the present time we have 31 AASM accredited sleep fellowship programs with others in the process of accreditation. By increasing the number of these fellowships we provide further evidence to ACGME that the training infrastructure is sufficient to sustain growth of the field. If you are considering accreditation of your program, please apply ASAP. Contacting Charlene Wibben (cwibben@aasmnet.org) at the national office will facilitate this process.

Under the enabling leadership of President-elect Dr. Andrew Chesson, the Board was also able to complete our strategic



plan at the March meeting. This plan provides direction for our efforts and actions over the next 3 to 5 years. Strategic goal #1 is aimed at promoting the field of sleep medicine. It states that "Sleep medicine will be widely recognized as an independent medical specialty." There are two major objectives that we will accomplish to achieve this goal. The first is to secure ACGME recognition for sleep medicine fellowships. The Board and staff have got the ball rolling, and with your help, it will gain momentum as we increase our AASM accredited sleep medicine fellowships to between 50 and 75 programs by 2005. The second objective is for the AASM to advance an academic model for Sleep Medicine. Currently, Harvard and the University of Pennsylvania have Divisions of sleep medicine. Others are needed and this will require significant effort. An AASM task force will be appointed to generate ideas and plan action items that will promote this process.

Additional strategic goals are focused in the areas of clinical care, education, research, advocacy and operations. Our vision statement has been slightly modified and now states: "The AASM is the leader in setting standards and promoting excellence in sleep medicine health care, education and research." Not only did the Board complete the strategic plan but this "gluttons-for-work" group also tackled revisions of the Bylaws at the March meeting. Led by Mr. Jerome Barrett with the assistance of Drs. Richard Rosenberg, Stuart Quan and Wolfgang Schmidt-Nowara, numerous changes were recommended,

including an increase in membership on the Board from 10 to 12 members. These revisions will be submitted to the membership for ratification.

Planning for the June 8-13th APSS meeting in Seattle has been smooth and efficient under the leadership of Dr. David White who chairs the Program Committee. We anticipate another outstanding meeting that will begin with 15 postgraduate courses scheduled for June 8th and 9th. A total of 21 symposia will be presented along with 9 discussion groups, 54 Meet the Professor sessions and 9 invited lectures. Out of the 760 abstracts submitted for presentation, 181 will be 10 minute oral presentations, 34 poster symposia (or panel discussions), and 529 poster presentations. For all of us who are optimists and elect not to carry an umbrella to Seattle, we will have AASM logo umbrellas available at the meeting, free of charge.

This year the Foundation will fund five grants at the level of \$30,000 per year for two years. This past years awardees have been highly successful in publishing their Foundation-supported research in high quality journals. While the AASM continues to be the major source of financial support for the Foundation, corporate support is increasing. Members of the Board have made personal contributions to the Foundation. Feeling guilty that you haven't contributed, make a gift and sleep well.

To promote good working relationships between the major patient (American Sleep Apnea and Insomnia Associations, Narcolepsy Network, Restless Legs Foundation), professional (AASM, SRS, APT and Academy of Dental Sleep Medicine), and public organizations (NSF), the AASM will again host a meeting of the Unity Council at APSS. During this meeting each organization will present its strategic goals. Areas of common interest will be identified and opportunities for co-sponsorship of programs explored.

As my Presidency draws to a close I would like to thank all of our hard working committee chairs for their continuing efforts on behalf of the AASM as well as Mr. Jerry Barrett and the dedicated, industrious AASM staff. The excellence of the AASM was recognized this year by the American Society of Association Executives. This organization gave us awards for excellence for both the APSS meeting and the journal *SLEEP*.

Drs. Donna Arand, Brian Foresman and the Accreditation Committee are to be complemented for producing a superb new accreditation manual that will greatly facilitate the process and quality of our accreditation program. Dr. Michael Littner and the Standards of Practice have continued the important work of publishing review and guideline documents. Dr. Mansoor Ahmed and the International Affairs Committee have established a mini-fellowship

program for foreign physicians to foster the development of sleep medicine in underserved countries. Dr. Baldwin Smith has been recognized for his many contributions as Chair of the Health Policy Committee by being appointed to fill the vacancy on the Board created by Dr. Tom Hobbins unexpected death. Dr. Bart Sangal also needs to be recognized for his efforts on our behalf at the January PEAC meeting where he presented current information on the costs of delivering sleep services.

Personally, I continue to be amazed by the rapid acquisition of new knowledge in our field. In the past year, I have learned that retinal ganglionic cells are the likely photoreceptors that send information on luminance to the SCN and that 22% of the patients I see in consultation have a pet sleeping on the bed with them.

WHAT WILL WE LEARN IN THE YEAR TO COME?

The past year has been both enjoyable and a tremendous learning experience. The AASM is a young, dynamic and growing organization. It has been my privilege to serve as President. I am confident in our future and look forward to working with Dr. Andrew Chesson as he assumes the Presidency at APSS this June in Seattle.

DEFINITIONS OF “NORMAL SLEEP QUANTITY AND QUALITY” TO BE DEVELOPED

The field of Sleep Medicine is facing an important challenge in defining normative sleep quality. Many providers are challenging the relevance of abnormal or mild sleep disorder states due to the lack of a normative sleep quality definition.

The Foundation is issuing a Request for Proposals (RFP) for a panel of experts to develop empirically-based definitions of normal sleep quantity and quality. The question of what constitutes “normative” sleep is a critically important one for clinical care, education, and research, but there are currently no widely-accepted guidelines.

This RFP is supported by an unrestricted educational grant from Pfizer, administered by the Foundation. Proposals must include a detailed budget, not to exceed \$75,000 in total.

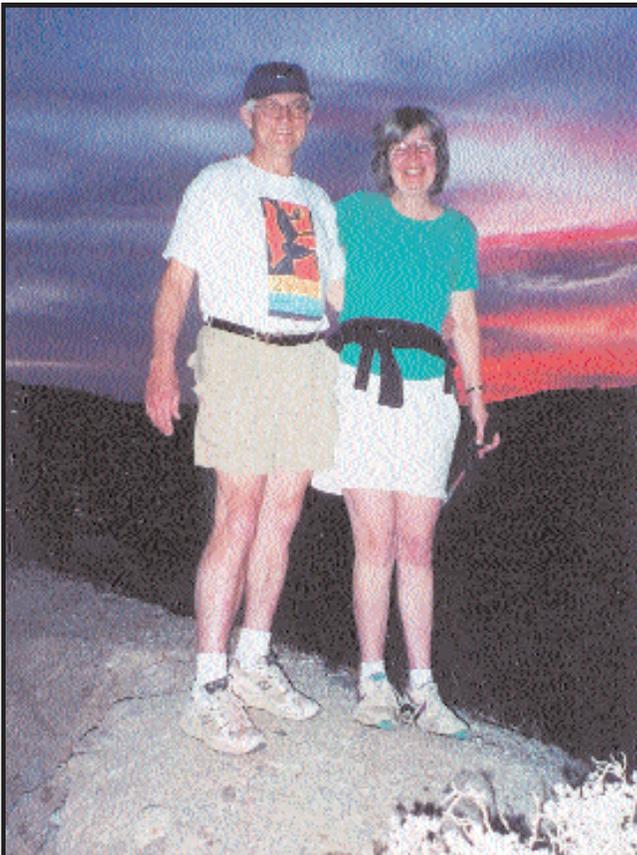
Two products are desired from this RFP. The first is a conference or symposium to present major findings and recommendations and the second is a set of integrative review papers, to be published together in a special issue of the journal *Sleep*, or as a separate volume

Interested individuals and groups should submit a brief (one paragraph) non-bind-

ing letter of intent by May 31, 2002. Final proposals must be received by July 1, 2002. For more information visit <http://www.aasmnet.org/Foundation/home2.htm> or contact the Foundation Coordinator at 507-287-6006.

History Book on the Discovery of REM Sleep to be Written

The American Academy of Sleep Medicine and Sleep Research Society have entered an agreement with Kenton Kroker, Ph.D., from McGill University, Montreal, Quebec, Canada to write a book on the history of the discover of REM Sleep. The book is to provide a historical account of sleep from the years 1870 - 1960. Dr. Kroker's book is to help commemorate the semi centennial anniversary of REM Sleep's discovery.



Dear Friends,

Here is a picture from our trip to the desert east of San Diego last fall to see the shooting stars. We camped out of sight and sound from all lights, roads, and other signs of civilization. Our site was quiet and the air was crisp, cool, and clear. We rested in a grove of palm trees, an old water hole which saved earlier explorers from desert dangers. The horizon, low but rugged, was only a few hundred yards away in all directions, as if we were protected in the palm of a gigantic hand. The picture was taken at sunset by a childhood friend, Bill Baity, who is an astronomer. The meteorites streaked ever so quickly across the nearly moon-less, cloudless sky. We stopped counting after 400. Bill brought along a group of "origin of life" scientists from Scipps Institute of Oceanography. Throughout the night they talked about the primordial soup which fueled the glorious heavens above our eyes and the sometimes less than heavenly life on earth below our feet. A night not to be forgotten.

Love to all of you,

Chris and Fran Gillin

COMMITTEE UPDATES

Accreditation Committee

The Accreditation Committee has approximately 60 applications in process for accreditation through the AASM. Fifty-two percent of these facilities are applying for reaccreditation and the others are new facility applications. The total number of facilities accredited by the AASM is currently 570. Eighty-seven percent of all AASM accredited facilities are full service centers.

The Reference Manual for Policies, Procedures, Documentation and Reporting has been completed by the Accreditation Committee and is now available for purchase. This product is intended for utilization by centers and laboratories as a guide to assist in the development of a Policies and Procedures Manual. Additional information on this product can be found on page 14.

Continuing Medical Education Committee

The Continuing Medical Education Committee received a four year reaccreditation from the Accreditation Council for Continuing Medical Education in late November 2001. Journal CME will now be allowed 15 weeks from the publication date to claim CME credit. CME has been approved for several educational activities in the coming months, including the APSS annual meeting and the National Sleep Medicine Course.

Fellowship Training Committee

The Fellowship Training Committee recently granted accreditation to two new fellowship programs and is in the process of reviewing several others. The new programs are Long Island Jewish Medical Center in New York City and New Mexico Center for Sleep Medicine in Albuquerque, NM. The current total of accredited Fellowship Training Programs is 31.

Government Affairs Committee

The Government Affairs Committee recently informed the membership via e-mail of the Medicare Physician Payment Fairness Act of 2001 and encouraged them to contact their elected officials via the AASM Legislative Action Center to support this bill. The Legislative Action Center can be found through the AASM website at: <http://capwiz.com/aasm/home/>. With the 2002 election year in full swing the, Committee is working on the AASM PAC breakfast fund raising event that will be held at the 2002 APSS Annual Meeting in Seattle, WA. The event is scheduled for the morning of June 9th in the West Ballroom of the Sheraton Hotel. Breakfast will be served from 6:30AM to 7:00AM. The guest speaker will address membership and meeting attendees about healthcare related issue and provide time for questions and answers. If you are interested in attending, you will be able to reserve your seat by signing up on the 2002 APSS Annual Meeting registration form (see the AASM PAC ad on page 31).

Health Policy Committee

The Health Policy Committee will be sending in the nomination of David Franco, M.D., to fill a vacant seat on the AMA's CPT Editorial Panel. Drs. J. Baldwin Smith, III, R. Bart Sangal, and Sam Fleishman presented CPT Codes 95810, 95807, 95808, and 95811 at the January meeting of the Practice Expense Advisory Committee (PEAC). The PEAC evaluates staff time, supplies and equipment for all services (See page 19 for the rest of the story.)

International Affairs Committee

The International Affairs Committee will be reviewing the applications received for the newly created international mini-fellowship program. The Committee has received several applications for this program. The Committee is continuing to evaluate the Academy's role in international educational endeavors.

Medical School Education Committee

The Medical School Education Committee continues to complete and post new educational products on the Academy website. The committee is also reviewing and updating the initial Sleep Academic Awards. Three new resources have been approved to be placed on the website, for a total of 52 available products. An additional 36 products are in the pending phase of production. The committee is looking to establish an Education Advocate Network that will identify education advocates at each of the medical schools in the U.S. and

Canada. These advocates will provide information to the Committee regarding the current state of sleep medicine education at their institutions.

Membership Committee

The Membership Committee has processed and the Board has approved the creation of a new section titled "Section on Surgery of the Upper Airway". The section chair designate will be David Bruce, D.D.S., M.D. Please see the chart for all section meeting times on page 12.

National Sleep Medicine Course Committee

The National Sleep Medicine Course Committee has been working on the coordination of this year's course and the development of an Advanced Sleep Medicine Course (ASMC). The 2002 National Sleep Medicine Course (NSMC) is August 10-14 and has been moved to a new location, North Dallas, Texas. The newly created ASMC is scheduled to occur in February, 2003, tentatively in San Antonio, Texas. More information on both of these courses can be found on page 16.

Publications Committee

The Publications Committee has placed the Narcolepsy and Sleep Apnea slides sets into a CD ROM format, and they are now available for purchase. Three new patient education brochures have been developed and are available for purchase (See order form page 37-38). The new brochures are titled *Drowsy Driving, Sleepwalking and Other Childhood Parasomnias, and Teenagers, Young Adults and Sleep*. These new brochures, as well as all the other Academy brochures, can be personalized with information regarding your member accredited sleep center. Contact Ryan Seaton at 507-287-6006 for order information or any questions concerning this member benefit.

Research Committee

The Research Committee has begun preliminary evaluation of the feasibility, field readiness, possible funding mechanisms, and infrastructure need for the development of a sleep clinical trials network. An

interest meeting will be held at this year's APSS meeting to determine the field's readiness and interest in this endeavor.

Standards of Practice Committee

The Standards of Practice Committee has recently submitted the following papers to the Journal *SLEEP* for publication: 'Practice Parameters for the Use of Auto-Titrating Continuous Positive Airway Pressure Devices for Titrating Pressures and Treat-

ing Adult Patients with OSAS' and 'The Use of Auto-Titrating Continuous Positive Airway Pressure for Treatment of Adult Obstructive Sleep Apnea'.

Academy of Dental Sleep Medicine to hold 11th Annual Conference

The Academy of Dental Sleep Medicine's 11th Annual Conference will be held June 6th—9th, 2002 at the Elliott Grand Hyatt in Seattle, Washington. This meeting will feature an international gathering of the leading clinicians, researchers and academicians working in the field of dental sleep medicine. This conference will run in tandem with the APSS Annual Meeting (Associated Professional Sleep Societies), giving participants access to the largest and best meeting of its kind.

Conference presentations will include the most up-to-date clinical applications and research in the field of dental sleep medicine relating to the treatment of sleep disordered breathing (snoring, upper airway resistance syndrome, sleep apnea). Some of the topics to be covered include avoiding complications with oral appliance therapy, diagnosis, and treatment options highlighting a broad range of oral appliances and surgical techniques. Attendees will have the opportunity to view vendor exhibits and learn about the latest technological advancements within the rapidly evolving field of dental sleep medicine. This year's conference will also feature oral appliance laboratory courses that will allow participants to gain practical experience while having an opportunity to interact with industry leaders providing supplies and equipment.

The program will also provide an introductory course for dentists new to the field. This is an ideal opportunity for both the novice and those participants who have qualified to take the Credentialing Examination June 10, 2002 to review the latest information. The conference is open to all interested dentists, physicians and technicians and continuing education credits are available for all those eligible participants.

For more information, contact:

American Academy of Dental Sleep Medicine

10592 Perry Highway, #220

Wexford, PA 15090

Phone: (724) 935-0836

Fax: (724) 935-0383

Email: info@dentalsleepmed.org

<http://www.dentalsleepmed.org>

ORGANIZATION NEWS

RELATED ORGANIZATION NEWS

The ABSM Part I Examination will be held on October 4, 2002, so be sure to visit the ABSM website at www.absm.org for future updates.

AMERICAN BOARD OF SLEEP MEDICINE EXAMINATIONS

Part II Examination

The American Board of Sleep Medicine Part II exam was held on April 8th, 2002. The exam took place in four locations: Irving, Texas; Oakbrook, Illinois; Tucson, Arizona and Tampa, Florida. There were 332 candidates registered. The ABSM Part II Committee worked diligently on computerizing this year's exam and for the first time ever, the Part II exam was presented in two formats: half printed recordings and the other half were viewed on a computer monitor with all answers hand written in examination booklets. All candidates were required to complete both the paper and computer portion of the exam. Candidates will be notified of the results of the Part II examination no later than June 15, 2002.

Part I Deadline

The deadline to submit ABSM Part I applications has passed. Applications postmarked after March 1, 2002 are not accepted, and no exceptions are made. Incomplete applications after April 1, 2002 were not included in the credentialing process. Notification of credentialing decisions will be mailed in late June 2002. Due to the elimination of waiver #2, there were over 750 candidates applying for the October 4,

2002 Part I examination.

The ABSM Part I examination will be held October 4, 2002. Be sure to visit our website at www.absm.org for future updates.

ABSM Designated Credentials

Have you passed both Part I and II of the American Board of Sleep Medicine (ABSM)? If so, please refer to yourself as a Diplomate of the ABSM, rather than only listing the acronym "ABSM" on your letterhead or after your signature.

You may use the following options to list your credential: Diplomate, American Board of Sleep Medicine; Diplomate, ABSM or simply D,ABSM. Using only the acronym "ABSM" as a credential is often confusing or misleading, as it infers you, the individual, are the ABSM or represent the ABSM.

Please help us to ensure we convey the correct message that the ABSM is the certifying authority for sleep medicine. For further information, please contact the ABSM National Office at 507-287-9819 or by e-mail at absm@absm.org.

FOUNDATION TO FUND FIVE TWO-YEAR GRANTS EACH AT \$30,000 PER YEAR

Promoting research in the field of sleep medicine has always been a top priority for the Sleep Medicine Education and Research Foundation (Foundation). To this end, the Foundation has funded a number of research grants over the past three years. Last November, RFPs for the 2002 Research Grants were publicized, announcing that the Foundation will be awarding five two-year grants each at \$30,000 per year. Fifteen proposals were received and are currently in the review process. Principal Investigators will be notified in June.

The Foundation is currently funding 14 two-year research grants. Two of these will conclude this spring and another six will be completed this fall. Several of these projects have submitted or are in the process of submitting proposals to the NIH for further research.

Current grant Principle Investigators include:

1999: Terri Weaver, PhD, RN; and William Dement, MD, PhD

2000: Radhika Basheer, PhD; Mahesh Thakkar, PhD; James M. Krueger, PhD; David P White, MD; Diego Contreras, MD, PhD; and Chiara Cirelli, MD, PhD

2001: Judith Owens, MD, PhD; Emmanuel Mignot, MD; Charles L. Wilson, PhD; Kenneth P. Wright Jr., PhD; Elda Arrigoni, PhD; and Sean P. A. Drummond, PhD

Research done in 1999 and 2000 includes publication of the following articles:

Basheer R, Halldner L, Alanko L, McCarley RW, Fredholm BB, Porkka-Heiskanen T. Opposite changes in adenosine A1 and A2A receptor mRNA in the rat following sleep deprivation. Neuroreport 2001;12:1577-80.

Basheer R, Rainnie DG, Porkka-Heiskanen T, Ramesh V, McCarley RW. Adenosine, prolonged wakefulness, and A1-activated NF-kB dna binding in the basal forebrain of the rat. Neuroscience 2001;104(3):731-39.

Taishi P, Sanchez C, Wang Y, Harding JW, Krueger JM. Conditions that affect sleep alter the expression of molecules associated with synaptic plasticity. Am J Physiol Regul Integr Comp Physiol 2001;281(3):R839-45.

In the near future the Foundation will be focusing on the sleep medicine education portion of its mission. Plans are underway to develop education awards, which will enhance the advancement of sleep medicine.

Keep checking the AASM weekly list serves, *AASM Bulletin*, and website for announcements on these new grant funding opportunities and other announcements for innovative fund-raising campaigns!

NATIONAL SLEEP AWARENESS WEEK HELD APRIL 1-7 2002

The National Sleep Foundation encouraged America to "Sleep for Success" during the 2002 National Sleep Awareness Week, which was held April 1-7. The week of activities took place just before we 'lost' an hour of sleep for Daylight Saving Time, and was designed to increase public awareness of the importance of sleep in our society today.

Each year, the National Sleep Foundation conducts a "Sleep in America" poll to discern the sleep habits—and sleep problems—of American adults. This year's poll focused on how sleep habits affect our daily lives. The poll results were released during the week of activities, which also included a major news conference at the National Press Club in Washington, DC; a Public Policy and Sleep Leadership Forum, and the gala awards dinner "Night of a Thousand Dreams."

The American Academy of Sleep Medicine was a co-sponsor of the Public Policy and Sleep Leadership Forum, which united those in the sleep field, Members of Congress, and volunteers to discuss sleep issues important to public safety and responsibility. Sleep advocates drew attention to problems such as drowsy driving and other public health issues related to sleep deprivation, and encouraged lawmakers to make these issues a priority for our nation's health and safety. In addition, they urged policymakers to increase funding for sleep research and to fund data collection on sleep issues.

The Academy joined NSF in this effort because the AASM has always made these topics a priority, and it supports efforts to increase public awareness of sleep and safety problems that the sleep field has known about for years. In fact, current research on professional and teenage

drowsy driving will be presented at the APSS Annual Meeting, as will a symposium that covers the public health issue of sleepy medical residents.

At NSF's "Night of a Thousand Dreams" gala, former AASM President Thomas Roth, Ph.D. was honored as one of the evening's awardees. In addition, Parents Against Tired Truckers was given the Advocacy award. The AASM congratulates all awardees and commends the NSF for its efforts to raise public awareness of sleep and sleep disorders.

Academy Section Meetings Schedule at APSS Meeting

AASM Members should mark their calendars to attend the AASM Section meetings during the APSS Annual Meeting in Seattle, Washington, June 8-13, 2002. The chart below provides you with the dates, times and locations of each of these meetings that have been scheduled as of press time. AASM members are able to be a member of only one section, but may attend as many section meetings as they desire.

Section	Date	Time	Room
Behavioral Sleep Medicine	Tues. June 11	6—7:30 p.m.	Juniper*
Dreams	Tues. June 11	7:30—9 p.m.	Juniper*
Freestanding Sleep Centers	Wed. June 12	6—7:30 p.m.	Madrona*
Medical Education	Wed. June 12	4—6 p.m.*	602-604*
Movement Disorders	Mon. June 10	6—7:30 p.m.	Douglas*
Neurology	Tues. June 11	6—7:30 p.m.	Douglas*
Oral Appliance Therapy	Mon. June 10	6—7:30 p.m.	Madrona*
Pediatrics	Tues. June 11	6—7:30 p.m.	Cedar*
Sleep Deprivation	Mon. June 10	7:30—9 p.m.	Madrona*
Sleep Disordered-Breathing	Mon. June 10	6—7:30 p.m.	Juniper*
Surgery of the Upper Airway	Wed. June 12	6—7:30 p.m.	Juniper*

*The Section on Medical Education in Sleep will meet jointly with the APSS Discussion Group, "Medical Education in the 21st Century." ♦ Sheraton Hotel ♣ Convention Center

International Affairs Committee to Sponsor Case Studies on International Sleep Centers

The American Academy of Sleep Medicine's International Affairs Committee requests that interested clinicians and researchers submit case studies for an informal discussion group that will be held at the 16th Annual APSS Meeting in Seattle, June 8-13. All interested clinicians and researchers should submit case studies for an informal discussion group scheduled for Tuesday, June 11, 2002, 5:30 in the evening, in Douglas Room at the Sheraton Hotel during the Seattle Meeting.

ton Hotel during the Seattle Meeting.

Presenters will share their experiences of starting and running a sleep center outside of the United States. Any individual who has first hand experience in operating a sleep center in countries outside the United States or any individual who has visited such a program is encouraged to submit an application to present their work. Presentations will be limited to ten slides.

This educational forum is sponsored by the International Affairs Committee in order to educate the Academy's membership of the experiences of sleep clinicians who are establishing sleep centers in areas outside of the U.S.

This year's presentations will represent the third year of the forum. Presentations from the previous two years have resulted in lectures regarding sleep centers in the countries of Japan, Egypt, Israel, England, and the People's Republic of China.

You may obtain a presenter form by contacting the National Office at 507-287-6006 Fax: 507-287-6008 or email gmader@aasmnet.org. The Committee looks forward to your submission and hopes to hear your presentation during the APSS Meeting in Seattle.

MEDSleep

Medical Education in Sleep

Do You Teach Sleep Medicine?

Save Time! Enhance your teaching and curriculum! Free educational resources for sleep instruction are available on the AASM website under MEDSleep! This site contains many different teaching tools, from *Power Point presentations* to *case studies*.

Whether you're interested in adding resources to existing sleep courses, or integrating sleep topics into other aspects of the curriculum, take advantage of these **FREE** resources today!



Visit

www.aasmnet.org/MEDSleep/medsleephome.HTM



member benefits

Take Advantage of the Convenience of the AASM Website

By Lois E. Krahn, M.D., Chair, Membership Committee

As a member, certainly you are aware of the tangible items membership brings into your office—the journal *SLEEP*, this *Bulletin* and informational mailings about the APSS Meeting and the National Sleep Medicine Course. However, are you taking advantage of one of the Academy's most outstanding benefits that is in your office every day?

Since 1995 your Academy has provided you with information electronically through the website at www.aasmnet.org. The Board of Directors wants you to take every advantage of the opportunities that the AASM provides you through our website.

From the homepage you'll want to view the blue rectangular buttons on the left hand menu and click on "Hot Spots." This button will take you to a listing of the more important current events in the field. This page will allow you to view and download information including:

- ✓ The new AASM accreditation standards
- ✓ Clinical guidelines
- ✓ Position papers
- ✓ Polysomnographic Technologists Job Description

Again from the homepage you can browse the MED-Sleep page by selecting the blue rectangular button from the home page menu. This page provides you with over 50 free products for you to use in lecture and for self-education.

Click on the "National Sleep Medicine Course" menu button and view the itinerary and faculty for this annual sleep medicine course held each August. (Members receive a \$400 discount on registration fees for this popular course!)

The Academy's website also provides you with links to the journal *SLEEP* at www.journalsleep.org. As a member, you have complete access to full text articles of every article ever published in *SLEEP* free of charge. You'll need to use your membership number for access

to view the journal online. Consult your copy of the Membership Directory for your membership number and catch up on 25 years of *SLEEP*!

A second important link from the Academy's website is the APSS Annual Meeting website at www.apss.org. You can view the entire meeting program and register for the meeting in Seattle (June 8-13, 2002) online. Register by April 22nd to take advantage of the "early bird" discount of \$75. Be certain to visit the Virtual Exhibit Hall on the APSS website to preview the exhibitors that will be present at this year's meeting.

The Job Board menu button allows you to view or post classified ads. Additionally, you can order any of the Academy's many educational products on the e-commerce site. You will have access to order information on slide sets, CD-ROM presentations (including the National Sleep Medicine Course), patient educational brochures, texts regarding the operation of your sleep center, and accreditation materials.

Log on www.aasmnet.org today to view any of these items mentioned above. You'll find that your membership dollar is providing you more information every day—without leaving the chair in your office.

American Academy of Sleep Medicine Business Meeting

All Academy members are encouraged to attend the American Academy of Sleep Medicine General Membership Meeting that will take place on Monday, June 10 at 12:30 P.M. in room 6D of the Washington State Convention and Trade Center in Seattle, Washington. Monday is the opening day of the APSS scientific meeting.

AASM Annual Report to be Released at APSS

The Annual Report of the AASM will be handed out in your meeting packet at the APSS Annual Meeting.

MEMBER BENEFITS CONTINUED ON PAGE 14

MEMBER BENEFITS CONTINUED FROM PAGE 13

The report is a comprehensive overview of the activities of the AASM over the last year, and includes topics such as Education, Voice and Advocacy, Communications, and Research, to name a few. In addition to our ongoing projects, the AASM has embarked on a number of exciting new initiatives in the past year, which will be covered in detail in the report as well.

In this document, AASM members can see how their membership dues are contributing to the ultimate advancement of sleep medicine, and those interested will be able to find out how they can get more involved in our organization activities.

To receive the AASM Annual Report, attend the APSS Annual Meeting—the report, among other things, is free with your registration.

Academy By-Laws Revision

Your Board of Directors has completed work on a review of the Academy's By-laws in order to bring these by-laws into accord with practices of the Academy. The revision was mailed on April 1 to the Academy's voting membership, along with the ballot for election of Academy officers for the coming year.

Please return your completed ballot by May 15, 2002.

Speakers' Database

The AASM International Affairs Committee is developing a list of sleep clinicians who are willing to travel to other countries where sleep medicine is less well known to advance the sleep specialty abroad. Presentations will depend on the needs of each individual case, but multi-day stays are currently being considered. These presentations may include lectures, practical demonstrations, case discussions, and

technical advice. Final lecture and travel arrangements will always be negotiated between the host and the invited sleep consultant. The Committee is attempting to facilitate the exchange of information and instruction by developing a list of members who would be interested in such an enterprise. The goal is to better match requests with visitors. Financial arrangements would most likely include travel and living expenses, but rarely a large honorarium.

If you are interested in becoming part of this endeavor, contact Greg Mader in the AASM National Office at gmader@aasm-net.org. Please provide your name, your specialty (a CV would be helpful), indicate what topics you would feel qualified to teach, maximum length you could be away from your practice and a list of countries to which you would be interested in traveling.

Need Help Developing Policies & Procedures?

The Accreditation Committee of the AASM has recently completed a guide entitled, "The Reference Manual for Policies, Procedures, Documentation and Reporting."

- ↻ 145 pages of templates and protocols that have been approved by the AASM Board of Directors.
- ↻ Will significantly reduce document development time for the medical director and technical staff.
- ↻ Includes protocols for administrative policies, emergency and safety procedures, equipment cleaning and inspection, office procedures, polysomnography procedures, quality assurance, scheduling of patients, plus numerous sample policies and procedures, clinic form and questionnaires.

The templates and protocols contained in this manual are suggested only, and may be used in whole or part. The use of these specific documents is not required for accreditation by the AASM.



To purchase your copy today, fill out the order form on page 37-38 or visit the AASM website at www.aasmnet.org

NATIONAL SLEEP MEDICINE COURSE MOVES TO NEW LOCATION WITH INCREASED CAPACITY

A distinguished faculty has been chosen for the 2002 National Sleep Medicine Course (NSMC), sponsored by the American Academy of Sleep Medicine. A review of the faculty list will reveal several experts who will share their knowledge over the course of five days through both formal and informal teaching sessions. Participants have the opportunity to interact directly with the faculty during question & answer sessions, poster review, and casually during meals. Lectures are supplemented by slide and video presentations; panel discussions and poster reviews offer a varied learning experience. In addition, participants have the opportunity to review and discuss sections from polysomnograms. The popularity of the poster sessions have resulted in digitally capturing over 130 polysomnograms that are posted on the AASM website for review after the course. Enhancements to the poster site that was launched last year are currently in progress and should be available by the conclusion of this year's course.

In order to meet the needs of the growing membership and also to address the elimination of ABSM waiver #2, the course has increased capacity by 100 seats.

The NSMC will be held August 10-14, 2002 at the Westin Stonebriar Resort in North Dallas, TX. The course brochure and registration information can be downloaded from the Academy website at www.aasmnet.org. Attendance is limited to 250 participants. Register early to secure your spot at the 2002 NSMC!

ADVANCED SLEEP MEDICINE COURSE TO BE INTRODUCED IN FEBRUARY 2003

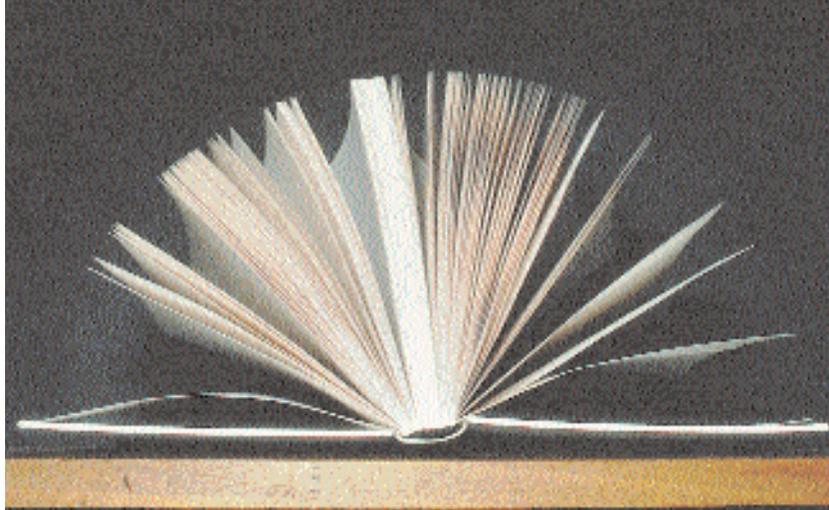
The AASM will introduce the first Advanced Sleep Medicine Course in February 2003, tentatively to be held in San Antonio, Texas. This comprehensive review of relevant clinical topics in sleep medicine, over the course of two and a half days is geared toward experienced sleep practitioners and diplomates of the ABSM.

Daily case-based Meet the Professor sessions and reviews of important topics will be delivered by an outstanding faculty of practicing and academic experts in sleep medicine, led by Course Director Eugene C. Fletcher, M.D. The course will cover recent developments in clinical sleep medicine including sleep disordered breathing, but advances in the diagnosis and treatment of narcolepsy, parasomnias, restless leg syndrome, and insomnia. Rather than reviewing topics in entirety, discussions will focus on the latest developments in diagnosis and treatment, recent research and publications, and the future of the field.

Additional details and registration information will be available this fall.

CM NEWS

EDUCATION



may 2002

Association Name	Meeting Name	Dates	Location
Sleep Research Society	Board of Directors Meeting	May 2	Conference Call
National Heart Lung and Blood Institute	Advisory Council Meeting	May 9—10	NIH
National Institute of Mental Health	Advisory Council Meeting	May 9—10	NIH
American Thoracic Society	International Conference	May 17—22	Atlanta, GA
National Institute on Aging	Advisory Council Meeting	May 21—22	NIH
National Institute on Nursing Research	Advisory Council Meeting	May 21—22	NIH
National Institute Drug Abuse	Advisory Council Meeting	May 22—23	NIH
Society for Research on Biological Rhythms	Annual Meeting	May 22—26	Amelia Island Plantation, Jacksonville, FL

june 2002

Association Name	Meeting Name	Dates	Location
National Institute of Child Health and Development	Advisory Council Meeting	June 3—4	NIH
European Sleep Research Society	Congress	June 3—7	Reykjavik, Iceland
National Institute on Alcohol Abuse & Alcoholism	Advisory Council Meeting	June 6	NIH
Academy of Dental Sleep Medicine	Annual Meeting	June 6—9	Seattle, WA
Associated Professional Sleep Societies	Annual Meeting	June 8—13	Seattle, WA
Association of Polysomnographic Technologists	Annual Meeting	June 9—12	Seattle, WA
American Medical Association	Annual Meeting of the House of Delegates	June 16—20	Chicago, IL

of events

YOU HAVE QUESTIONS? WE HAVE ANSWERS!

Q: Is there a reimbursement code for Oral Appliances?

A: Sleep Centers are using mainly miscellaneous codes when evaluating and fitting patients for oral appliances. Several centers use the miscellaneous code 99002 -22 for fitting patients with an oral appliance. This miscellaneous code is for "...services provided in connection with the implementation of an order involving a device which is fitted and adjusted by an attending physician." The 22 modifier is for a unique service. When using miscellaneous codes it is important for physicians to document in detail the service being provided.

There is a HCPCS code for the oral device, S8260. Medicare will not pay for this code, but the code may be used with private insurers.

Q: Can a CPAP mask be re-used?

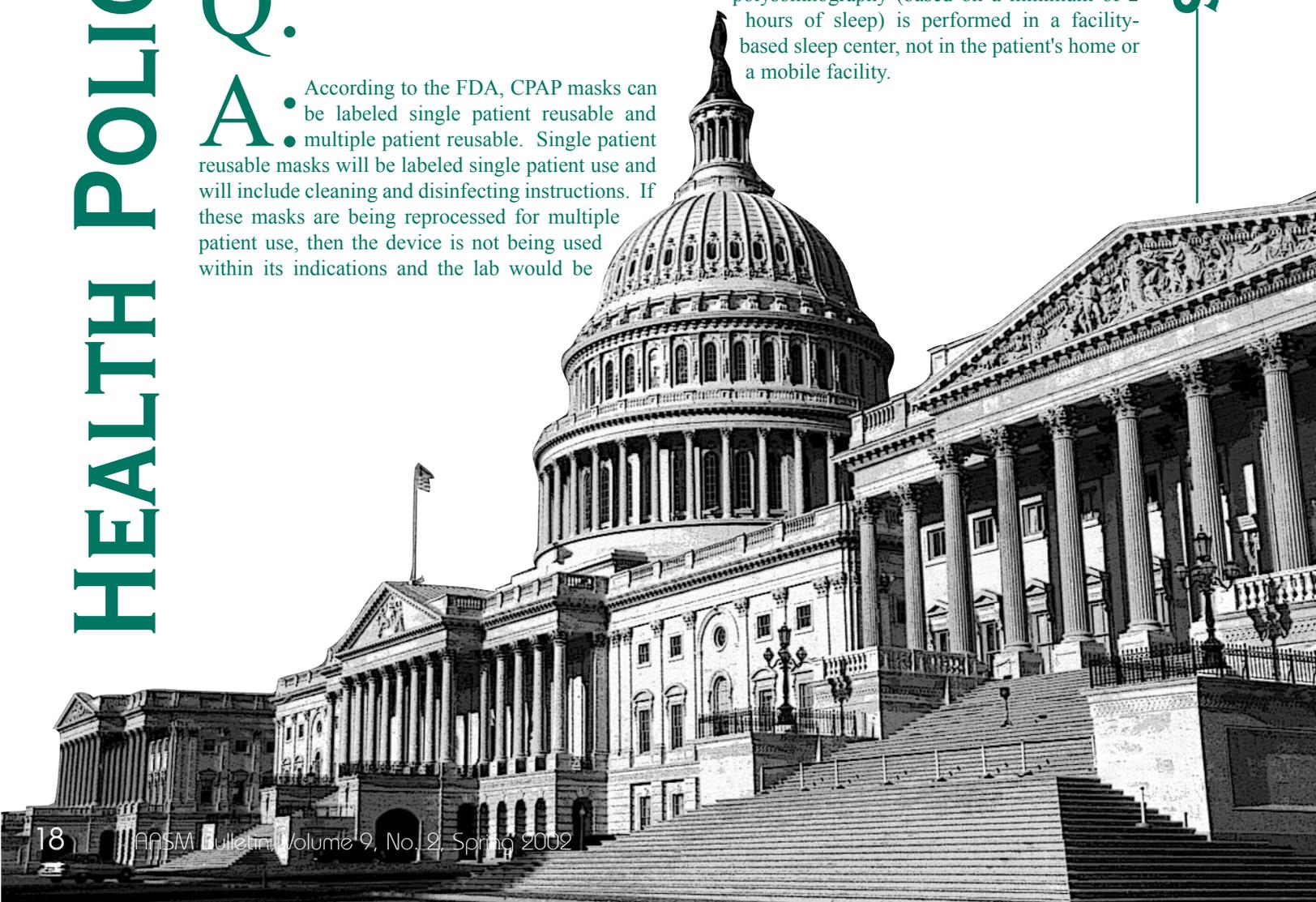
A: According to the FDA, CPAP masks can be labeled single patient reusable and multiple patient reusable. Single patient reusable masks will be labeled single patient use and will include cleaning and disinfecting instructions. If these masks are being reprocessed for multiple patient use, then the device is not being used within its indications and the lab would be

subject to FDA enforcement. Masks labeled multiple patient reusable can be reprocessed as indicated by the manufacturer's label and reused.

Q: When does the new CMS Medicare coverage policy for CPAP take effect?

A: The new CPAP coverage policy is scheduled to take effect on April 1, 2002. The new policy allows for CPAP coverage for patients with obstructive sleep apnea (OSA) if either of the following criteria is met:

Apnea-Hypopnea Index (AHI) ≥ 15 events per hour, or AHI ≥ 5 and ≤ 14 events per hour with documented symptoms. Both apnea and hypopnea are defined in the manual instruction and all claims for CPAP devices must be supported by information in the patient's medical record indicating that the patient meets Medicare's coverage criteria for CPAP. In addition, Medicare will only cover CPAP if a polysomnography (based on a minimum of 2 hours of sleep) is performed in a facility-based sleep center, not in the patient's home or a mobile facility.



Newsbriefs

President's 2003 Budget Released

President Bush released his FY 2003 budget plan to Congress. The \$2.1 trillion proposal reflects the President's priorities for the coming year and provides a starting point for Congressional deliberations over spending on government programs. The President's budget contains \$190 billion over 10 years in new spending for improvements to the Medicare program, including a drug benefit, which is the same increase he requested last year but far less than what lawmakers from both parties believe is necessary. Congress set aside \$300 billion for a drug benefit in its FY 2002 budget resolution. This year, House Republicans are expected to propose a plan that would cost about the same amount or slightly more than that. Enactment of a new benefit is considered unlikely due to budget constraints, however, in an election year politics, anything is possible.

Meeting with House & Senate Committee Members

On March 20, 2002, Dr. Wolfgang Schmidt-Nowara, Government Affairs Committee Chair and Dr. Allen Pack, Research Committee Chair represented the Academy in meetings with members of the House & Senate Labor, Health & Human Services and Education (L-HHS) Appropriations Subcommittees. The American Academy of Sleep Medicine used these meetings to familiarize the key appropriation staffers with the field of sleep medicine, including advances and opportunities in research and to request that report language be included into the FY 2003 L-HHS appropriations bill. Specifically, the suggested report language requests that the National Center for Sleep Disorders Research and the National Heart, Lung and Blood Institute (within the National Institutes of Health) continue its work to advance research into the relationship between obstructive sleep apnea and obesity, hypertension, cardiovascular diseases and mortality. The Academy requested that the Institute accelerate these efforts through multi-site clinical studies to assess effective treatments for patients with sleep apnea and other sleep disorders. The report language was well received and staff seemed interested in submitting the language to the Subcommittee. The Academy will continue to keep you updated on this issue.

2002 Physician Conversion Factor

The AASM, along with the AMA and many other physician groups, stepped up their campaign for relief from the 5.4 percent reduction in Medicare payments that went into effect Jan. 1. The administration's FY 2003 budget contains no new spending to ease the cut and states that any increase must be offset by reductions elsewhere. At a House Budget Committee hearing Feb. 28, Health and Human Services Secretary Tommy Thompson told lawmakers he would provide them with recommendations on how to boost payments to some providers while offsetting those increases with cuts to others.

Many members of Congress acknowledge the need to revise the way payments for physician services are updated each year, but must weigh the sizable budgetary costs of making any changes that result in positive updates. Moreover, the AARP has told Congress that it opposes increases in payments to providers unless action is taken on prescription drug coverage for seniors.

Two key House Committees held hearings on the update formula in February. Members heard testimony from CMS, MedPAC, CBO, and groups representing physicians, seniors, and other health professionals affected by the across-the-board reduction. In announcing the Feb. 28 Ways and Means Health Subcommittee hearing, Chairman Nancy Johnson stated: "Medicare's formula for paying physicians is completely irrational and must be reformed this year. These cuts are unjustifiable. They result from factors in a formula that has nothing to do with the cost of providing health care."

At the Ways and Means hearing, MedPAC reiterated its recommendation that Congress should "repeal the SGR and instead require that the Secretary update payments for physician services, based on the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity." This recommendation would result in an update of 2.5 percent for 2003. CMS now projects four years of negative updates under the current formula. MedPAC's recommendation comes with a big pricetag, however. CBO estimates that repealing the SGR system would increase Medicare spending by \$126 billion over 10 years.

In testimony before the Energy and Commerce Health Subcommittee, CMS Administrator Tom Scully acknowledged the volatility of the current update formula and said he would work with Congress and the physician community "to smooth out the yearly adjustments to the fee schedule in a way that is budget-neutral across all providers."

January 2002 PEAC Meeting

At the January 2002 meeting of the AMA's Practice Expense Advisory Committee (PEAC) Drs. J. Baldwin Smith, III, R. Bart Sangal, and Sam Fleishman presented CPT Codes 95807, 95808, 95811, and 95810. These codes were up for review at the request of the PEAC which evaluates practice expenses - staff time, supplies and equipment. The information presented by AASM was drawn from a survey sent to 87 freestanding sleep centers/labs, of which 30 responded. The survey data showed a reduction in clinical labor time and equipment as compared to the data CMS had been using for the Medicare Physician Fee Schedule. The PEAC requested further reductions in clinical labor time. For these reasons a reduction in relative values used to calculate Medicare reimbursement is anticipated. The results of the PEAC meeting are considered confidential until CMS has published the final rule in November. The final rule should be published in November. It is anticipated that there will be a reduction in the practice expense values for the technical component of the CPT codes that were presented. These anticipated reductions would be limited to polysomnography services provided in freestanding centers and physician offices. The Academy will notify membership when the final decisions are made available.

Medicare Regulatory Relief

A recent report by the General Accounting Office confirms physicians' longstanding complaints about the inadequacy of the information provided by Medicare carriers. GAO found that information provided to physicians by CMS through its carriers is "often difficult to use, out of date, inaccurate, and incomplete." The agency also found that CMS conducts insufficient oversight of carriers. GAO analysis revealed problems with each of the three main methods that Medicare carriers use to communicate information to providers: Medicare bulletins, carrier call centers, and carrier web sites.

NEWS BRIEFS CONTINUED ON PAGE 20

GAO found, for example, that Medicare bulletins, used by some carriers as the primary means of communication with physicians, are poorly organized, contain dense legal language, are incomplete, and fail to provide information about program changes. To assess the accuracy of information provided by customer service representatives (CSRs), GAO called 61 carrier call centers and posed three "frequently asked questions." The CSRs answered only 15 percent of the calls completely and accurately, according to GAO. In its review of carrier web sites, the agency found that most of those reviewed did not contain features that would allow physicians to quickly and directly obtain the information they needed.

In its report, GAO noted the actions CMS has already taken to improve its communications to physicians. The agency recommended CMS take additional steps, however, including:

- Publication of a national bulletin for physicians, in addition to issuing a quarterly compendium of regulations.
- Establishing new performance standards for carrier call centers that emphasize providing complete and accurate answers to physician inquiries.
- Setting standards and providing technical assistance to carriers to promote consistency, accuracy, and user-friendliness on all carrier web sites.
- Strengthening its contractor evaluation and management process by relying on expert teams to conduct more substantive carrier performance evaluations on physician communications activities.

GAO's report "is further proof that the Medicare program is too big and too burdensome and is in serious need of fundamental reform," stated Rep. Jim Nussle (R-IA), House Budget Committee Chair and one of the House members who requested the report. Nussle called on the Senate to take up the Medicare Regulatory and Contracting Reform Act passed unanimously by the House last December.

The report, "Medicare: Provider Communications Can Be Improved," is available on the Budget Committee's web site at <http://www.house.gov/budget/>.

Patient Privacy

In a Feb. 26 letter to OMB and HHS, Reps. Bill Thomas (R-CA) and Nancy Johnson (R-CT) urged changes to the medical privacy regulation "to ensure that patients' sensitive medical information is protected and that life-saving health research will continue to advance unabated." The two identified four main problems with the

rule: the definition of "de-identified information"; the transition rules for existing medical records; new requirements for research protocols subject to Institutional Review Board (IRB) review; and barriers for reporting information to health registries. "It is critical these problems are addressed prior to moving forward with any final rule," Thomas and Johnson wrote. OMB is currently reviewing proposed changes to the medical records confidentiality rule, according to the letter.

The letter is a follow up to one Thomas and Johnson wrote last May detailing their concerns with the final rule. "Since our last letter, we are even more certain this rule will cause great damage to medical research and are recommending additional changes to the regulation," they stated. The Feb. 26 letter recommends the following changes:

- "Because removing all identifiers makes research virtually impossible, we recommend modifying the definition of de-identified to require direct identifiers such as name and health plan number be removed, but that indirect identifiers critical to advancing patient research remain.
- Grandfather the use and disclosure of existing archival information for research purposes.
- Establish a 'regulatory authorization' structure to allow covered entities to use patient information for several defined purposes. Eliminate the requirement for IRBs to evaluate the potential risk of loss of privacy to the individual versus the potential benefit of the research to the individual.
- Allow reporting to all public health registries without patient consent."

Centers for Medicare and Medicaid Services, Hospital Outpatient Regulations

On February 28th, CMS announced publication of the final rule establishing new payment rates to hospitals for services performed in outpatient departments. The new rates go into effect April 1, 2002. Under pressure from providers, CMS delayed implementation of—and made technical corrections to—the final rule issued Nov. 30. "For virtually every service, the new rule sets payment rates equal to or slightly higher than in the November rule," CMS said in the announcement. Among the services that will see "significant increases" are PET scans, certain electrophysiological evaluations, and placement of certain intracoronary stents.

The final rule can be viewed by going to http://www.access.gpo.gov/su_docs/fedreg/a020301c.html and scrolling down to the Centers for Medicare & Medicaid Services.

Medicare Coverage Policies Made Easy: How Decisions are Made

By John Whyte, M.D., MPH

One of the first questions physicians, device/drug manufacturers and patients ask when a therapy is being considered is whether or not it will be paid for by insurance. As the largest insurance program, Medicare often sets the standards for what is covered. In the last three years, Medicare has made significant changes to the process it uses to make coverage decisions in an attempt to make the program more understandable, predictable, and timely.

The federal agency that administers the Medicare program is the Centers for Medicare & Medicaid Services (CMS). CMS was formerly known as the Health Care Financing Administration HCFA. This authority is granted under Section 1862(a)(1)(A) of the Social Security Act, which restricts all coverage and payment to that which is found "reasonable and necessary" for the treatment of illness or injury. This provision gives Secretary of Health and Human Services Tommy Thompson, acting through CMS, the authority to determine the coverage of services under Medicare.

The statute is actually phrased in the negative, stating that we "shall not pay for those services which are not reasonable and necessary for the treatment of illness or injury...." Because of this phrasing, the premise that a device or procedure might be of benefit to some patient, in some circumstance, is not a criterion upon which the Medicare program can base coverage decisions. There needs to be evidence of effectiveness. In addition, the statute is generally interpreted to mean that Medicare does not cover prevention. Those preventive services that Medicare does cover (e.g. colorectal screening, mammography, PSA screening) have all been mandated by Congress.

When discussing Medicare coverage, it is important to keep in mind that Medicare is a defined benefit program. A service must fall into a statutorily-defined "benefit categories" as a first step toward coverage. These are broad categories, such as physician services, physical therapy, laboratory, diagnostic services, and durable medical equipment. The reason why Medicare, in general, does not cover outpatient prescription drugs, is that there is no benefit category for outpatient drugs. In addition, there must be no statutory exclusions to coverage.

For example, Medicare does not cover hearing aids or eyeglasses.

NEWS BRIEFS CONTINUED ON PAGE 24

APSS ANNUAL MEETING OFFERS THE LATEST IN SLEEP SCIENCE, ADDRESSES PUBLIC HEALTH ISSUES

The 16th Annual Meeting of the Associated Professional Sleep Societies is more than just another convention.

The APSS meeting offers the latest in sleep research and technology, as well as addresses sleep topics currently in the public spotlight. Anyone working in the sleep field—practitioners, researchers, students, educators, editors—can't afford to miss it. APSS is the place to brush up on the most recent findings on common sleep disorders, such as sleep apnea, as well as discover new information about breakthrough treatments not yet available to the public.

The 2002 Postgraduate courses will be held on June 8th and 9th. The APSS Program Committee carefully chose a wide variety of course topics in order to offer something for every sleep professional. The courses this year will cover the latest research in melatonin, dental sleep medicine, polysomnogram interpretation, pediatric parasomnias, and other topics.

The Scientific Sessions begin on Monday, June 10th with opening ceremonies. Keynote Speaker David F. Dinges, Ph.D. will be speaking on "Manifestations of Sleepiness: What Does It Mean to Be Awake?" The sleep community will also join in recognizing 2002 award recipients at the ceremonies.

The scientific sessions held over the next four days (10th - 13th) include symposia, discussion groups, oral and poster presentations, and meet-the-professor sessions. Some of

these sessions cover specific research interests, and others address issues affecting every sleep professional in the U.S. and the world. Many outside the sleep field know that sleep and sleep disorders are topics covered in the news daily. Members of the field, however, have expressed a need to know the scientific facts surrounding these reports, so that they can be prepared with a balanced and scientifically sound response to public health issues.

Dr. Daniel Buysse will be chairing a symposium to discuss the current research on sleep and mortality, which was a major news story in February. Another APSS symposium will discuss post-disaster sleep disturbance and how sleep clinicians can best help these patients, such as those suffering from sleep problems following the September 11th attacks. The long hours held by medical residents have been a hot topic gaining media attention in recent months, and a discussion group at the meeting will consider solutions to address the problem of drowsy residents with impaired judgement.

Due to the quantity of high-quality science proposed for the meeting, the APSS Program Committee has scheduled up to 6 sessions simultaneously. Of course, the examples above are only a sampling of the research and

issues that will be addressed at the meeting; over 700 more topics will be presented from the 2002 abstract submissions alone. The science presented at APSS is important information for every sleep professional, and this forum provides a once-a-year opportunity to get informed and stay current in the field.

For more information on the courses or scientific sessions for APSS 2002, see the preliminary program, which was mailed in mid-February. An electronic preliminary program as well as registration for the meeting are available online at www.apss.org.

Your best bargain: Only a few days remain before the April 22nd early bird registration deadline—register online today at www.apss.org and receive immediate confirmation of your attendance via e-mail.

The 16th Annual Meeting of the Associated Professional Sleep Societies will be held June 8-13, 2002, in Seattle at the Washington State Convention and Trade Center, the Sheraton Seattle Hotel and Towers, and the Westin Seattle.



After falling into a benefit category, a service must then satisfy CMS' process for determining whether it can be considered "reasonable and necessary." There have been several attempts over the past decade to explicitly define these words, although no rule has actually been adopted. The criteria remain implicit, rather than explicit.

A much-misunderstood aspect of the Medicare program is that there are actually two general methods by which Medicare coverage decisions are made. The first is through local carrier discretion. Medicare contractors develop coverage policies, known as Local Medical Review Policies (LMRPs). Within a few months, they will be called local coverage determinations or LCDs. (See www.lmrp.net to review these local coverage policies.) Medicare contractors consult with a group of local practicing physicians on a Carrier Advisory Committee, and then publish LMRPs in their local bulletin. At the same time, CMS may develop national coverage policies.

Very few people understand that most new items and services are covered by the first process, with only about 10% covered by second. Both methods rely upon evidence of medical effectiveness; as a result, people often find it confusing when there is disparity in policies. For instance, a beneficiary may be able to get transurethral needle ablation of the prostate in one state, but not another. This disparity due to carrier discretion is an acknowledgement that physician practice varies by geography. If all policies were determined at the national level, there might be slower diffusion of technology. Whereas local policies can be overturned for individual patients by administrative law judges, there is only limited review for national coverage policies.

As mentioned earlier, CMS recently changed its process for making national coverage policy. The April 27, 1999, Federal Register outlines the administrative process and attempts to explain how an issue enters the national process and how it is handled through to a coverage decision. Within the past 30 months, nearly 40 national coverage decisions have been made under this new process. They can all be reviewed at www.hcfa.gov/coverage. Anyone interested in the national coverage decision should review this notice.

In general, the process focuses on a review

that is evidence-based with continued emphasis upon authoritative evidence and demonstrated medical effectiveness. We want to see:

- Benefits outweigh reasonably-anticipated risks
- Evidence of improved health outcomes (functional outcomes)
- Compliance of the device or procedure with all regulatory requirements

Approval by the Food and Drug Administration (FDA) is a prerequisite but not a guarantee for coverage. The FDA determines that a device or drug is safe and effective; the FDA gives products access to the market. CMS needs to decide if the product is worth purchasing. With respect to devices, most medical devices are not approved under a rigorous Premarket Approval application (PMA), but rather "cleared" by the FDA under a 510(k) application.

Under this clearance process, a device simply needs to be substantially equivalent to a device that existed on the market prior to 1976 when the Food Drug Cosmetic Act was passed. Less than 10% of 510(k)'s require any clinical data. Most of the application is focused on technical performance of the device. In 2000, less than 50 devices received PMA; the rest underwent 510(k) review.

So companies need to plan accordingly, recognizing that the CMS and FDA processes are not the same, and are meant to answer slightly different questions. There is an effort to better coordinate these processes, and manufacturers should speak with both agencies at the time of product development.

The process for asking CMS to consider a national coverage determination is simple, and CMS encourages any member of the public to see a national coverage determination. To do so, one simply needs to:

- Submit in writing a "formal request for a national coverage decision"
- Provide supporting documentation
- List a full description of service in question, including benefit category
- Compile medical/scientific information currently available
- Describe clinical trials underway

Within approximately 150 days, CMS will respond to such a request. Possible decisions include:

- **Actual decision:**
 - o National noncoverage
 - o Carrier discretion
 - o National coverage without limitations

o National coverage with limitations

· **Order technology assessment:** In general, we expect these assessments to be completed with three to six months.

· **Referral to Medicare Coverage Advisory Committee (MCAC):** The MCAC presently includes 75 members representing a broad range of disciplines, including clinical medicine, public health, data and information management, economics, ethics). There are six panels (Medical/Surgical, Drugs/Biologics/Therapeutics, Laboratory, Diagnostic Imaging, Medical Devices, Durable Medical Equipment and an Executive Committee. A non-voting industry and consumer representative sits on each panel. The MCAC makes recommendations concerning the adequacy of the evidence. The majority of national coverage determinations do not go to the MCAC, but rather only a handful of the most difficult cases.

Within 180 days of a national coverage determination, we hope to have implemented any program changes and made payment effective. A common source of confusion is that there is often a timelag between when we announce a national coverage decision and when it is actually covered, throughout payment systems.

Again, this is meant to be an open and inclusive process. We are maintaining a current list of issues we are considering for national coverage decisions, as well as those for which decisions have been made. This is an exciting time to be involved in medical technology. CMS encourages everyone to become involved in this new process. Be sure to check out our website www.hcfa.gov.

John Whyte, M.D., MPH, is medical officer/senior advisor for the Coverage and Analysis Group at the Centers for Medicare & Medicaid Services in Washington. He can be reached by e-mail at JWhyte@cms.hhs.gov.

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2002 IS AN ELECTION YEAR



What's the most important thing you can do this election year other than vote?
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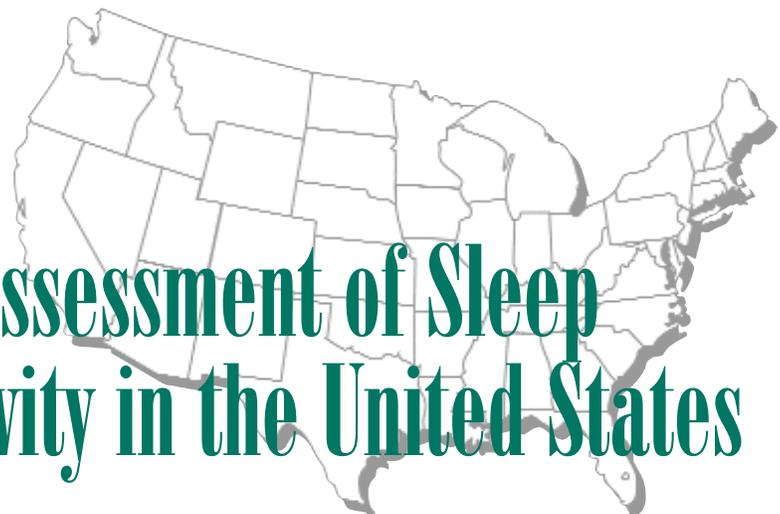
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feature:

A Quantitative Assessment of Sleep Laboratory Activity in the United States



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INTRODUCTION

Over the last 20 to 25 years, the use of clinical sleep laboratories to diagnose and treat a variety of sleep-related conditions has increased dramatically. Most such activity has evolved around the recognition of obstructive sleep apnea as a common disorder with important adverse neurocognitive and cardiovascular outcomes.^{1,2} The diagnosis of sleep apnea and the initiation of therapy are most commonly accomplished in the sleep laboratory with overnight polysomnography. Despite the apparent increase in sleep laboratory activity, there has been no quantitative assessment of the number of sleep studies conducted in the United States. We sought to determine the number of sleep laboratories and sleep studies conducted in the United States at the current time, and, to some extent, to assess variability in sleep testing in different areas/states within the United

States (U.S.). In this project, we did not address the number of ambulatory or home studies.

METHODS

To estimate the number of sleep laboratories and overnight sleep studies performed per year in the United States, we first mailed a brief questionnaire to all American Academy of Sleep Medicine (AASM) accredited sleep centers in the U.S., excluding Puerto Rico, and all individual members of the AASM. This questionnaire was mailed in March 2001 with all utilized responses received by June 1, 2001.

We then selected three states in which to undertake a more precise assessment of the number of laboratories/sleep studies performed (Massachusetts, Oregon, and Louisiana). We selected these states because they are approximately equal in population, but represent a diversity of socioeconomic status and geography. To more precisely determine the number of sleep studies performed, we identified phone numbers and addresses of all known AASM members and sleep laboratories in these states (from AASM listings and telephone directories). We then contacted every AASM member (or accredited center) who did not respond to the original survey by telephone or by email to obtain information concerning the number of polysomnograms performed per week. We also asked about other laboratories in their area and contacted these physicians/clinicians as well.

Once we were confident that we knew precisely the number of sleep laboratories and

polysomnograms conducted in these three states, we could then determine the percentage of laboratories/studies identified by the original survey: [actual number of sleep studies (or labs)/ number from the original mail survey]. This ratio was then used to extrapolate the actual number of laboratories/studies conducted in the other 47 states.

The number of sleep studies per capita was calculated by dividing the number of sleep studies performed per year by the country's or state's population (from the U.S. Census year 2000).

RESULTS

We sent surveys to 507 accredited sleep centers and 3,697 AASM members. A total of 725 surveys were returned. This represented information from 633 individual sleep centers (i.e. 92 were duplicate responses). The number of responses obtained from each state is shown in Table 1 (column 6). Overall, data were obtained from 262 AASM accredited sleep laboratories (52% response rate) and 371 non-AASM accredited laboratories.

We were able to contact and obtain the needed information from all known sleep centers in Louisiana (29 laboratories), Oregon (20 laboratories), and Massachusetts (34 laboratories). Twenty-four (29%) of these sleep centers were accredited and 59 were not. Of these 83 laboratories, 41 of them responded to the original mailed survey (i.e. response rate=49%; ratio of number of actual/responder laboratories=2.041). The response rate of accredited laboratories (14/24, 58%) and non-accredited laboratories (27/59, 46%) were

Table 1—Number of PSG's Performed in the United States According to State

State alphabetical	Number of PSG/year Reported from mail survey	Total estimated number of PSG/year*	Population	Number of PSG/year/100 000 population**	Number of responding labs (mail survey)	Estimated Number of labs***
Alabama	18980	32646	4,369,862	747.1	16	33
Alaska	2288	3935	619,500	635.2	3	6
Arizona	8034	13818	4,778,332	289.2	6	12
Arkansas	6110	10509	2,551,373	411.9	8	16
California	39728	68332	33,145,121	206.2	44	90
Colorado	2860	4919	4,056,133	121.3	5	10
Connecticut	11596	19945	3,282,101	607.7	14	29
Delaware	1040	1789	753,538	237.4	1	2
District of Columbia	1768	3041	519,000	585.9	1	2
Florida	38272	65828	15,111,244	435.6	36	73
Georgia	31044	53396	7,788,240	685.6	21	43
Hawaii	2470	4248	1,185,497	358.4	3	6
Idaho	4368	7513	1,251,700	600.2	6	12
Illinois	32682	56213	12,128,370	463.5	30	61
Indiana	18512	31841	5,942,901	535.8	16	33
Iowa	6032	10375	2,869,413	361.6	10	20
Kansas	7930	13640	2,654,052	513.9	11	22
Kentucky	14820	25490	3,960,825	643.6	14	29
Louisiana	10322	17754	4,372,035	406.1	14	29
Maine	2912	5009	1,253,040	399.7	6	12
Maryland	34918	60059	5,171,634	1161.3	13	27
Massachusetts	19006	32690	6,175,169	529.4	17	34
Michigan	40560	69763	9,863,775	707.3	29	59
Minnesota	10400	17888	4,775,503	374.6	8	16
Mississippi	6604	11359	2,768,619	410.3	6	12
Missouri	12792	22002	5,468,338	402.4	10	20
Montana	2938	5053	882,779	572.4	5	10
Nebraska	4836	8318	1,666,028	499.3	5	10
Nevada	4576	7871	1,809,263	435.0	4	8
New Hampshire	5096	8765	1,201,134	729.7	6	12
New Jersey	13520	23254	8,143,412	285.6	13	27
New Mexico	4524	7781	1,739,844	447.2	4	8
New York	31720	54558	18,196,601	299.8	28	57
North Carolina	13962	24015	7,650,789	313.9	11	22
North Dakota	3432	5903	633,666	931.6	3	6
Ohio	34580	59478	11,256,654	528.4	30	61
Oklahoma	2782	4785	3,358,044	142.5	3	6
Oregon	8632	14847	3,316,154	447.7	10	20
Pennsylvania	33904	58315	11,994,016	486.2	33	67
Rhode Island	2808	4830	990,819	487.5	2	4
South Carolina	9464	16278	3,885,736	418.9	7	14
South Dakota	1456	2504	733,133	341.6	2	4
Tennessee	21658	37252	5,483,535	679.3	19	39
Texas	27560	47403	20,044,141	236.5	32	65
Utah	11180	19230	2,129,836	902.9	7	14
Vermont	624	1073	593,740	180.8	1	2
Virginia	16588	28531	6,872,912	415.1	18	37
Washington	15548	26743	5,756,361	464.6	14	29
West Virginia	5460	9391	1,806,298	519.9	7	14
Wisconsin	14092	24238	5,250,446	461.6	19	39
Wyoming	416	716	479,602	149.2	2	4
Total	677404	1165135	272,690,258	427	633	1292

*For Louisiana, Oregon, and Massachusetts, this value was obtained through telephone/email contact with all known sleep laboratories. For the other states, this value was generated by multiplying the number of PSG's as reported from the mail survey by 1.72 (see text)

** This value was calculated by dividing column three with column four

*** For Louisiana, Oregon, and Massachusetts, this value was obtained through telephone/email contact with all known sleep laboratories. For the other states, this value was generated by multiplying the number of laboratories that responded to the mail survey by 2.041 (see text)

not significantly different ($p=0.34$, Fisher's exact test). Assuming a similar response rate from all the laboratories in America, we estimated that 1292 sleep centers are present in the United States (i.e. 633×2.041). The number of sleep centers in each state (except LA, OR, and MA) was estimated in a similar manner (Table 1, column 7).

The number of sleep studies performed each year in each of the three index states was 18,580 (LA), 18,127 (OR), and 28,509 (MA). As expected, this number was greater than that reported from the returned mailed questionnaires (i.e. 10,322, 8,632, 19,006, respectively). The ratio of sleep studies determined from direct contact with the centers versus the mail survey was 1.72 when data from all three states were pooled together (ratios of 1.8, 2.1, and 1.5 for LA, OR, and MA respectively).

The reported number of yearly sleep studies performed in each state (solely from the mail survey) is shown in Table 1 (column 2). The number of studies determined from the in-depth analysis described above for Massachusetts, Oregon, and Louisiana is also shown in Table 1 (column 3) for those three states. For the other states, an estimate of the actual number of PSG conducted yearly was calculated by multiplying the number of studies reported by the mail survey by 1.72 (Table 1, column 3). Using this technique, the total number of PSG performed per year in America was 1.17 million or 427 per 100,000 population.

The per capita PSG rate varied tremendously between states (Table 1, column 4). The fewest number were performed in Colorado (121 PSG/year/100,000 people) and the most in Maryland (1116 PSG/year/100,000 people). We attempted to identify significant predictors of state PSG variability. Not surprisingly, there was a strong correlation between the per capita number of sleep laboratories and the per capita rate of PSG's (Spearman correlation coefficient=0.632, $p<0.001$). There was a weak relationship between the state per capita rate of sleep studies and the per capita number of AASM members (Spearman=0.40, $p=0.004$). However, the per capita rate of PSG in each state was not

Table 2—Primary Specialty of the Sleep Laboratory Director

Primary Specialty	Accredited Center	Non-Accredited Center
Pulmonary	50.8%	54.2%
Neurology	16.4%	17.7%
Sleep Medicine	6.5%	7.0%
Psychology	6.5%	1.1%
Psychiatry	4.2%	1.9%
Pediatrics	2.7%	2.4%
Internal Medicine	1.9%	3.5%
Other specialty	2.7%	6.7%
Pulmonology and Neurology	3.4%	1.3%
Pulmonology and another specialty	3.1%	1.6%
Other combinations	1.5%	1.3%
No director	0%	1.1%
No answer	0.4%	0.3%

correlated with risk factors for OSA (mean age, percentage of males), suggesting that utilization was not distributed according to disease prevalence. Socioeconomic factors (poverty level and median income), Medicare reimbursement rates for PSG, percentage of uninsured, population density, race, and geographic location (West Coast, East Coast, Mid-West, South-West) were also not predictors.

The per capita number of sleep laboratories correlated with AASM member density (Spearman=0.32, p=0.02) and weakly with the Medicare reimbursement rate (Spearman=-0.27, p=0.06) but not with any other variables.

We asked the primary specialty of the director in all mail surveys in the United States (Table 2). The majority of sleep laboratories in the United States, both accredited and non-accredited, were directed by pulmonologists with the next most common specialty being neurology.

DISCUSSION

This is the first study that has attempted to determine the annual number of sleep studies conducted in the United States. We found that in 2001, there were 1.17 million PSG's conducted over the last year (427 PSG's/100,000 population). There was substantial state to state variability ranging from 121 to 1161 studies/year/100,000 population.

We were also able to estimate the number of sleep laboratories in the United States (approximately 1292). In our three index states, only a minority (29%) of laboratories were accredited suggesting that the

majority of sleep centers in America are not accredited by the AASM. The distribution of PSG utilization in the United States varied considerably between states. There was a weak association between the number of AASM members per capita and the rate of sleep studies performed, which may explain some of this variability. However, we were surprised that other variables known to be associated with utilization of healthcare resources were not.^{3,4,5} In particular, socioeconomic status, geographic location, Medicare reimbursement rates, race, and distribution of OSA risk factors were not associated with the per capita rate of sleep studies. Thus, at the present time, the explanation for the varied distribution of sleep study utilization in America remains unclear.

We recognize that the accuracy of our estimates may have been compromised for a variety of reasons. First, we relied on self-reports to obtain information about the number of PSG conducted in each laboratory. The accuracy of such reports may have varied. However, we doubt there would be a consistent over or underestimation of the number of PSG's. Consequently, given the large number of responses obtained in our study, we doubt this substantially affected our results. Second, we may not have identified all sleep centers in the United States as we relied primarily on AASM lists. Some individuals running sleep laboratories may not be AASM members. This may have been particularly important in our three index states. Nevertheless, we doubt the number of overlooked labs was large or led to substantial underestimation of laboratories or studies. Third, we have assumed that the

ratio of the actual number of sleep studies/laboratories divided by the number determined from the mail survey was the same in all states. Although some error in individual state estimates was almost certainly introduced by this assumption, we believe this to be a reasonable assumption as the ratio in our three index states was relatively similar. We therefore believe our results to be a reasonably accurate representation of the rate of sleep studies performed in the USA.

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Viewpoint

History and Structure of Sleep Medicine at the University of Michigan

Ronald D. Chervin, MD, MS, and Sid Gilman, MD, FRCP

Intensive interest in sleep medicine at the University of Michigan began nearly 25 years ago in the Department of Psychiatry, which wired 53 hospital beds for sleep studies in patients with several different psychiatric disorders. The volume of these studies gradually diminished, along national trends, but psychiatry maintained a separate two-bed sleep laboratory for many years. With strong support from Sid Gilman, MD, Chair of Neurology, Michael S. Aldrich, MD, started the first outpatient sleep disorders laboratory at this institution in 1985, in a single room of the outpatient surgical suite. The lab relocated and grew twice before 1997, when a \$1.6 million renovation created a nine-bed, state of the art facility on the eighth floor of the main hospital. The Psychiatry Sleep Lab was merged into the new lab run by Neurology. AASM Accreditation for the Sleep Disorders Center has been maintained since 1987. At the peak of a remarkable career, Dr. Aldrich succumbed to cancer in 2000. In that year, the laboratory was renamed as the Michael S. Aldrich Sleep Disorders Laboratory, and Ronald D. Chervin, MD, MS became its Director.

Each week, the Sleep Disorders Center evaluates about 90 patients in clinic and performs about 60 nocturnal sleep studies during seven nights of operation. An accredited sleep medicine fellow-

ship is slated to enroll three full-time sleep fellows for the 2002-2003 academic year. An average of 6 neurophysiology fellows also spend one-third or more of their 1 to 2-year fellowship in the sleep laboratory. All neurology residents rotate through the sleep clinic, but residents of other departments do not.

Sleep Center faculty include four full-time adult neurologists, all board certified or prepared for the boards in sleep medicine. The faculty also includes a pediatric neurologist who is a member of the Departments of Pediatrics and Neurology, and also holds board certification in sleep medicine. A sleep board-certified psychologist spends 20% of his effort at the Sleep Center. Staff members based at the Sleep Laboratory include several fellows, twenty technicians, several research associates, administrative personnel, and a physician's assistant. The Laboratory houses a unique, multidisciplinary Alternatives to a CPAP Program that coordinates care for sleep apnea patients who do not tolerate CPAP therapy. Patients see an otolaryngologist, an oral and maxillofacial surgeon, a dentist, and a sleep specialist during one clinic visit, and these specialists formulate recommendations at an interdisciplinary conference at the end of the afternoon. A host of additional faculty participates in clinical research in sleep medicine. They include professionals with expertise in nursing, endocrinology, neurology, pediatrics, family practice, otolaryngology, dentistry, oral and maxillofacial surgery, and health outcomes.

VIEWPOINT CONTINUED ON PAGE 31

In 1999, two preeminent basic science sleep researchers were recruited to the University of Michigan Department of Anesthesiology. Each of these senior-level appointments—one to a named professorship—brought outstanding basic science laboratories and training programs. Since then, an additional associate professor and assistant professor have been hired within the Department of Anesthesia, with joint appointments in pharmacology or physiology. These four basic science groups greatly enhance educational opportunities in sleep medicine at our institution. Interaction between these groups and clinicians occurs at monthly research conferences and more informally in other venues.

The Department of Neurology operates the Sleep Disorders Center, which nonetheless enjoys outstanding multidisciplinary clinical contributions from Pediatrics, Psychology, Dentistry, Otolaryngology, and Oral and Maxillofacial Surgery. Efforts to further expand involvement of faculty in other departments, such as Pediatrics and the Division of Pulmonary Medicine, have met challenges that arise from desires of these Departments to share in Sleep Laboratory profits. Currently the University of Michigan has a faculty group practice, but little revenue generated in the practice becomes shared across individual departments. Consequently, individual depart-

ments must be financially viable. Sharing the profits of any of its clinical laboratories, including EEG, EMG and Sleep, would seriously impair the financial viability of the Department of Neurology. The Sleep Disorders Center has been highly productive, enjoys a wide breadth of interaction with specialists from different fields, and has made research contributions in many different areas of sleep medicine. However, until the financial barrier can be overcome, efforts to further enhance the multidisciplinary composition of our Center will continue to be a challenge.

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Accreditation FAQ

The Accreditation Committee receives many calls and e-mails from Academy members and other individuals with questions relative to the process for the accreditation of centers and laboratories. Below you will find some of the most frequently asked questions and the corresponding answers, which were supplied by Dr. Donna Arand, Chair of the Accreditation Committee. If you have questions specific to the accreditation process, please e-mail them to Karin Anding at the national office (kanding@aasmnet.org) and we will consider placing them in future issues of the *AASM Bulletin*.

1. Where can I find the AASM Standards for Accreditation?

The AASM Standards for Accreditation can be printed from the AASM website at www.aasmnet.org/process.htm#guidelines.

2. What does the scoring scale for the AASM Standards for Accreditation mean?

The level of compliance with each standard can be scored on the associated scale. A few standards are essential and can only be scored "pass" or "fail". Any program that scores a "fail" on any of these standards will not be accredited until it meets the standards. The remaining standards are scored on a scale ranging from 1 to 5. These scores represent the degree of compliance with the

standard, with 1 indicating that the standard has been met or exceeded. Higher numbers indicate room for improvement, and the outlined numbers indicate a deficiency which reaches the level of a proviso. In this way, programs can objectively evaluate their level of compliance with the Standards prior to the site visit, using the same scoring system utilized by the site visitor(s). At present, the total score is not used for evaluation.

3. Does the Medical Director have to be board certified in sleep medicine?

The Medical Director does not have to be board certified in sleep medicine. However, the center staff must include a Diplomate of the American Board of Sleep Medicine (D,ABSM), or an individual who has been accepted to sit for the ABSM certification examination. Accredited laboratories are required to have an ABSM Diplomate, or an individual who has been accepted to sit for the ABSM certification examination, on staff within three years of the date of accreditation. In many cases, the medical director is an ABSM Diplomate.

4. What is the difference between the codes designated in the ICD-9 (International Classification of Diseases) and those in the ICSD (International Classification of Sleep Disorders)?

The ICD-9 codes are intended for the classification of diseases for reimbursement purposes, while ICSD codes are intended for the specific diagnosis of sleep disor-

ders. Sleep centers or laboratories that are accredited by the AASM may use both codes; however, the ICSD must be used for terminology and diagnosis.

5. Does a Diplomate of the ABSM have to read each record in its entirety?

If the Diplomate is the interpreting physician, then the entire record must be read in detail. If the Diplomate is co-signing another physician's interpretation, then the Diplomate must review an adequate amount of the raw data to feel comfortable that the interpretation is correct.

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CLASSIFIEDS

SEEKING EMPLOYMENT

MEDICAL DIRECTOR OF A SLEEP CENTER/FULL TIME SLEEP MEDICINE PHYSICIAN—Sleep Medicine fellowship trained, Diplomate of ABSM, MD, Ph.D., is looking for a position of a Medical Director of a Sleep Center/full time Sleep Medicine Physician. Three years experience in the treatment of a wide spectrum of sleep disorders, teaching fellows, research in the busy sleep program of the tertiary academic hospital and private practice. Please, reply by e-mail: sleepphys@hotmail.com.

POSITIONS AVAILABLE

MEDICAL DIRECTOR OF SLEEP PROGRAM—The Pulmonary and Critical Care Medicine Section of Baylor College of Medicine and The Methodist Hospital are seeking a Medical Director of the Sleep Program at The Methodist/Diagnostic Hospital to assume leadership of this clinical and research program. Candidates should be Board Certified in Pulmonary and Critical Care Medicine and Sleep Medicine, and have several years of experience in Sleep with publications related to sleep medicine. Successful applicants should be clinician scholars who can direct and develop a comprehensive program including patient care, education and clinical research. Interested candidates should send a letter, CV, and names of three references to: Al Davies, M.D., Chair of Search Committee, Medical Director of Sleep Program, Pulmonary-Critical Care Section, Department of Medicine, Baylor College of Medicine, 6550 Fannin, SM1225, Houston, Texas 77030, adavies@bcm.tmc.edu. Baylor College of Medicine is an Equal Opportunity, Affirmative Action and Equal Access Employer.

PEDIATRIC PULMONARY SPECIALIST TRAINED IN SLEEP MEDICINE—The Sleep Medicine Institute at Swedish Medical Center invites applications for a Pediatric Pulmonary Specialist trained in Sleep Medicine. This full-time position has been created due to expansion of the clinic's pediatric specialty services and will add to a staff of three ABSM certified sleep physicians, two nurse practitioners and a large pediatric multi-specialty group. The Sleep Medicine Institute operates 14 sleep testing beds. Responsibilities will include medical direction of the pediatric sleep medicine clinic, diagnosis and treatment of patients with sleep problems and sleep related breathing disturbances, and establishment of medical standards of the use of CPAP and Bi-PAP on children. A general pulmonary practice component is available with the pediatric group. The ideal candidate will be personable, energetic and demonstrate a desire

to promote pediatric specialty services within the community. Successful applicant will be BC/BE in Pediatric Pulmonary Medicine and board certified in Sleep Medicine or has an active, approval application on file with the ABSM. Excellent salary and benefits. For more information, please contact Jacqueline Carie, Physician Recruiter at (206) 215-2454. Fax your CV in confidence to (206) 215-2975 or email jacqueline.carie@swedish.org.

SLEEP FELLOWSHIP

FELLOWSHIP IN SLEEP DISORDERS MEDICINE: UNIVERSITY OF CHICAGO—A one or two year Sleep Disorders Medicine Fellowship (AASM accredited) program is available for applicants starting in July 2002 and also July 2003. The Sleep Fellowship Program is also integrated with the Clinical Neurophysiology Program (ACGME approved) of the Department of Neurology. Active clinical sleep research with Dr. Eve Van Cauter, as well as exposure and participation in Pediatric, Pulmonary and research activities. New spacious eight bed facility with extensive computer facilities (database, networking). Very active Sleep Disorders Clinic (over 600 news, 1800 revisits). Staff includes six AASM Boarded faculty. Candidates must be board eligible in Psychiatry, Neurology, or Internal Medicine. Inquires and CV to: Dr. Jean-Paul Spire, The University of Chicago, Department of Neurology, 5758 S. Maryland Ave., MC 9019, Chicago, IL 60637, Tel: 773-702-1780, Fax: 773-702-7998 Email: jpspire@neurology.bsd.uchicago.edu

Do you qualify to offer AASM-sponsored CME credit?

In November 1997, the American Academy of Sleep Medicine was awarded full accreditation by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. Since that time, the AASM CME Committee has worked to establish guidelines and procedures to enter into joint sponsorship agreements with organizations not accredited to sponsor CME educational activities. At this time, the Committee is pleased to announce its intent to accept applications from AASM accredited member centers and laboratories and other entities for joint sponsorship with the AASM.

If you are interested in offering CME credit for physician educational activities, please contact Jennifer Markkanen at the AASM National Office by phone at (507) 287-6006, or by e-mail at jmarkkanen@aasmnet.org for additional information and an application for CME credit.

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