

## DO YOU PROVIDE BOTH SLEEP DIAGNOSTIC AND SLEEP DME SERVICES? *by Duane Johnson PhD*



Patients typically prefer continuity of care from their doctors, or 'one stop shopping' as we might call it. While you may wish to provide sleep DME service along with your sleep diagnostic service, there are many patient service, financial, operational and legal considerations to explore first. A number of sleep professionals are successfully providing both.

When integrated well, the patient typically receives improved sleep DME service, the sleep lab has increased referrals as word gets out, and the sleep service financial bottom line is enhanced.

Recently, I had the opportunity to ask Bryan Spear, BA, CRT, RCP, Sleep DME Specialist, the most frequent questions I receive from sleep lab physicians and managers, who are investigating an expansion of their sleep patient care services to include sleep DME services. Mr. Spear is a very experienced sleep DME professional and sleep lab manager as well as a contributing author to SCMI's manual, *How to Start a Sleep DME Business*. Here are the answers he provided to my questions:

**Q. Where should you see the sleep DME patients? In the office or sleep facility, or at their homes?**

Scheduling of sleep DME patients is basically the same as scheduling for sleep diagnostic patients. Patients can be scheduled to come to the office or facility with which they are familiar. This provides patients some comfort in returning to the same place where their sleep testing took place. Fitting patients in the office or

facility or in their home when a patient has mobility or transportation issues must be considered in scheduling. Most patients prefer to come to a professional setting for sleep DME care as opposed to having a national home health company send a CPAP or BiPAP in a cardboard box that a delivery service places on their doorstep. Quality of treatment service standards is an issue here. Everyone must work together to raise quality assurance standards.

Also, at the time of scheduling, payment of sleep DME service and any available payment options offered the patient should be explained, including deductibles and co-insurance payments.

NOTE: It has been my personal belief that a licensed clinician should be available for the interaction and fitting of sleep related equipment, a non-clinically trained person may be able to set-up that equipment as well as anyone, but will not have the clinical training to monitor physiologic or medical problems a patient may experience in a routine or emergency situation. Look into the cost of office or facility insurance liability, and clinician liability insurance in regard to the fitting of the equipment. All vendors carry a large general liability insurance policy on equipment they sell.

**Q: Do I need to pre-certify, or pre-authorize DME service & sales?**

Sleep DME pre-certification is commonly required by most third party payor organizations in order to qualify for reimbursement benefits. Since most payors will assess penalties and reduced benefits for non-contact certification of care provided, the reimbursement margin is greatly reduced or the patient is confronted with an uncomfortable payment obligation. When the collection of the allowable payment is reduced or slowed pending re-billing, cash flow will be negatively impacted.

**Q: What differences are there in billing sleep DME as opposed to sleep diagnostic?**

Billing is quite different. Most offices are familiar with CPT procedure codes but not with CPT codes that involve an actual product. For example, depending on the requirements from the insurance provider sleep DME equipment can at times be initially rented for an indefinite amount of time, up to the average purchase price of the equipment. This in turn involves your billing department more in follow-up and re-billing on a monthly basis on the core items (CPAP, Bi-Level, and Heated Humidifier) to collect on the equipment. Remember if your office doesn't bill it, it doesn't get paid! All non-reusable items (such as hoses, masks, pillows, chinstraps, and headgear) are always purchased because no other patient can use them if returned as stated by the Department of Health's standard regarding use of contaminated and previously used equipment.

**Q: What do I need to focus on for follow-up of a sleep DME Pt.?**

The follow-up for sleep DME is far more involved than sleep diagnostic follow-up. It used to be that the patient was scheduled, fitted for sleep equipment, and sent on his way, never to be heard from again...this is the way of the past.

With that in mind, an effective follow-up program must coordinate the patient, sleep lab, and physician interaction. It should

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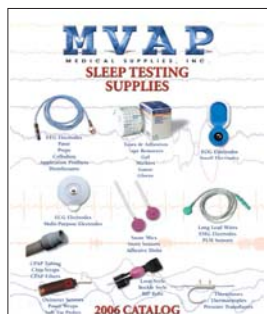
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or correction is not so much in applying the corrections, as analyzers can provide corrections automatically. The issue is that normal value ranges are at 37°C. Temperature corrected values should not be evaluated with eutermic normal ranges. Reporting temperature adjusted norms and temperature adjusted results would be a logistical nightmare, not to mention the fact that normal ranges have not been validated for hypothermia and hyperthermia. For example, the significantly hypothermic patient has lower oxygen consumption. What PO<sub>2</sub> value is considered hypoxemic at 34°C, at 32°C? Other practical considerations arise with temperature adjustment of blood gases. When was the temperature taken, was the temperature oral, axillary, skin surface or rectal? Body temperatures are site variable. Because of these considerations most authors recommend against temperature correction of blood gas results for most applications.

A growing number of blood gas labs are offering electrolytes along with blood gases. The preanalytic error in electrolyte analysis from inadequate line waste clearance was previously discussed in part two of this series. Another significant source of electrolyte error is from sample hemolysis. Intracellular potassium is approximately 23 times higher than plasma potassium. As a consequence, hemolysis will result in spuriously elevated potassium. In contrast, ionized calcium decreases with hemolysis as intracellular calcium is only about one thousandth of extracellular Ca levels. Hemolysis is usually not a concern in whole blood testing but can occur in several situations. Storing samples in ice water slurry can increase friability of RBCs. Over-vigorous mixing of iced samples can subsequently cause hemolysis and spurious values for K and ionized Ca. Withdrawing arterial or venous samples too rapidly or active aspiration through a small needle can also cause hemolysis.

The most serious and potentially most deleterious error is sample/patient misidentification. There is no such thing as the "right" results on the wrong patient. Diligence and careful practices can avoid misidentification. The practice of using two forms of ID (name, med record number and/or DOB) along with bar code labeled syringes can significantly reduce identification errors.

Hopefully, these three articles have given readers a better appreciation of sources and possible consequences of preanalytic error. The following practices will reduce preanalytical error potential: 1) identify the patient positively, 2) avoid air in the sample, 3) avoid analysis delay, 4) mix well but gently 5) when drawing from a line remove 2x deadspace prior to sampling.



**"I've lived a full life. I've been divorced, audited, sued and indicted"**

involve a pre-determined 72-hour, 10-day, 30-day, and 3, 6, 9, and 12-month schedule with specific goals and tasks for each set increment. Each patient follow-up must be well documented in the patient file so that it can be effectively evaluated with any issues of non-compliance or troubleshooting being addressed.

When interviewing pre-existing CPAP/Bi-Level patients, 54% commented that they had their accessory equipment (mask, hose, headgear) for the same length of time as their actual machine, 43% of the same patients commented they had never been contacted after the initial fitting from the DME company that originally visited them. Also of the previous 43% of patients, 100% commented their machine pressure had never been tested for two to four years.

*Q: How do I find affordable equipment for my patient?*

Most vendors will work with a sleep facility that has integrated DME. Since both facilities are in need of this equipment, it is in the vendors' best interest to give the best price possible to continue to supply both facilities. The primary vendors are very competitive and will be very good at creating purchase options. Contracting vendor agreements are very popular in attempting to achieve the desired cost per unit required to be profitable in the sleep DME market.

*Q: What type of compliance program is necessary for quality patient care?*

After the initial fitting the patient can be entered into an equipment compliance program. Of course it can be offered with the patient option to opt out if so desired which would then make them responsible for the re-order of supplies when the need arises. The compliance program would ensure that the patient receives supplies at the manufacturer recommended specification for replacement, giving them the benefit of proper fitting comfortable equipment.

The initial follow-up within 72 hours of the sleep DME service is done to record any issue that the patient may be experiencing with pressures, interface fit, and any additional general questions on education, warranty, adjustment and operation of equipment.

At the 10 day follow-up, the technician will verify with the patient the cleaning procedure, education issues, and compliance, hours used, number of nights per week, and any issues with interface fit, pressure, comfort, and machine adjustments. The 30-day follow-up requires the same parameters conveyed in the 10 day.

Starting with the 90-day follow-up the equipment compliance program will begin, and subjective information will be recorded from the patient in compliance data logs. At this time the patient will make visit arrangements to have compliance data downloaded from their equipment. This information is sent to the physician for review. The data transfer process is repeated every 90 days for the first year.

At the 6 and 9 month follow-up the patient will cover subjective information, any issues with equipment and replacement of supplies. All issues will be addressed with the patient.

The 12-month follow-up includes supply re-orders and subjective information from the patient. A notification is sent to the sleep facility/physician that the patient needs to be scheduled for a one-year re-titration to prove efficacy and necessity of therapeutic treatment. This can be especially useful in cases where a patient has a significant weight gain/loss or some other change that would require a change in current treatment to insure it remains effective.

Should you provide both sleep diagnostic and DME services? There is not a simple answer but it is worth your business evaluation.

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