innovatesleep

Application for AASM's Innovation Care Delivery and Management Program for Patients with OSA

DEMOGRAPHICS AND OWNERSHIP INFORMATION OF FACILITY

Name of Facility _____

Affiliated with _____

Mailing Address _____

Location Address _____

Phone _____ Email _____ Fax _____

Main Facility Contact Person

Name _____

Phone _____ Email _____

Independent Diagnostic Testing Facilities (IDTF) may NOT be eligible to participate in the Innovation Care Delivery and Management Program. Final determination of participation eligibility will be made by CMS in March 2012. The application submitted by AASM did not exclude IDTFs from participation; however, because of certain restrictive rules CMS currently has in place, it is not a guarantee CMS will accept IDTFs for this program.

Ownership Information

Name of Person/Entity Holding Legal Ownership of Sleep Facility _____

Check One: ☐ Hospital Owned ☐ Hospital Under Contract with Outside Group ☐ Freestanding ☐ Other _____

Geographic Location (check one): ☐ Urban ☐ Rural ☐ Suburban

CURRENT ACCREDITATION INFORMATION

AASM Center Accreditation ☐ Yes ☐ No Accreditation Number _____

AASM Out of Center Sleep Testing (OCST) Accreditation ☐ Yes ☐ No Accreditation Number _____

DME Accreditation ☐ Yes ☐ No

Who Provides DME Accreditation? _____

Date of DME Accreditation _____ Date DME Accreditation Expires _____

FACILITY INFORMATION

Number of Beds _____ Patient Age Range in Years _____

Number of **NEW** Medicare Patients Seen Per Year: 2011_____ 2010_____ 2009_____

Professional Staff Members in Facility: TWO REQUIRED (list all, attach additional sheet if needed)

1. Name _____

   Title _____

   Degree _____ Phone _____ Email _____

   Boarded in Sleep Medicine ☐ Yes ☐ No Primary Contact ☐ Yes ☐ No

   Designated Sleep Specialist ☐ Yes ☐ No Hours/Week in Sleep Facility _____

2. Name _____

   Title _____

   Degree _____ Phone _____ Email _____

   Boarded in Sleep Medicine ☐ Yes ☐ No Primary Contact ☐ Yes ☐ No

   Designated Sleep Specialist ☐ Yes ☐ No Hours/Week in Sleep Facility _____

Technical Staff Members in Facility (list all, attach additional sheet if needed)

1. Name _____

   Title _____

   Certification _____ Phone _____ Email _____

   Scoring Technologist ☐ Yes ☐ No

2. Name _____

   Title _____

   Certification _____ Phone _____ Email _____

   Scoring Technologist ☐ Yes ☐ No

3. Name _____

   Title _____

   Certification _____ Phone _____ Email _____

   Scoring Technologist ☐ Yes ☐ No

4. Name _____

   Title _____

   Certification _____ Phone _____ Email _____

   Scoring Technologist ☐ Yes ☐ No

Administrative Staff Member(s) in Facility

1. Name _____

   Title_____ Phone _____ Email_____

2. Name _____

   Title_____ Phone _____ Email_____

PRACTICE INFORMATION

Does your practice currently provide DME equipment to non Medicare/non Medicaid patients? ☐ Yes ☐ No

Do you own the DME equipment you provide to Medicare/non Medicaid patients? ☐ Yes ☐ No

CRITERIA

The criteria for site selection into the pilot program include the ability to complete the following before or during the initial six month start-up period:

- Have AASM Sleep Center Accreditation and AASM Out of Center Sleep Testing (OCST) Accreditation
- Purchase adequate equipment/supplies to become a DME supplier to the patients enrolled in the Integrated Program
- Sign an agreement with the AASM to remain in the pilot program for a minimum of three years
- Form a group sleep medicine practice with one or more credentialed sleep medicine physicians; individual consideration will be given to rural sites related to this requirement
- Demonstrate that the entity has the capability to produce outcomes data on a prescribed (monthly or more frequent) basis and to provide the data to the AASM in the prescribed format prior to each published deadline
- Commit staff from the facility to attend a mandatory training program and also participate in frequent calls to discuss best practices as well as to problem solve
- Design and create a Compliance Program specific to each pilot program location
- Commit to develop an outreach program to promote evaluation and testing of patients exhibiting symptoms of OSA which includes providing patient education programs and developing patient support groups
- Commit to develop a referral network of community physicians (e.g., dentists, surgeons, PCPs) to ensure patient is not lost after the diagnosis of OSA
- Achieve Medicare DME accreditation through the AASM if not currently accredited

ATTESTATION

The signature below indicates that I am the official from this organization authorized to attest and certify that all of the information provided in this application is true and complete. I have read and will comply with the definitive criteria contained in this document if my site is selected as a participant in the AASM Innovation Care Delivery and Management Program for Patients with OSA.

Authorized Official

Name (print) _____

Signature _____ Date_____