The practice of sleep medicine is a relatively young specialty. Physicians in this field generally focus on sleep care as a subspecialty after completing their primary specialty residency training in family medicine, internal medicine, otolaryngology, pediatrics, psychiatry, pulmonology, or neurology. Although the practice-expense characteristics of these primary specialties have previously been tracked and analyzed to provide a basis for establishing practice-expense relative values under the Medicare program, the June 2009 Physician Practice Information (PPI) Survey was the first of its kind to isolate and survey the specialty of sleep medicine. This paper presents baseline information from the PPI Survey that, for the first time, identifies expenses associated with the practice of sleep medicine.

Survey Background

The PPI Survey, created by the American Medical Association (AMA) and administered from 2007-2008 by The Gallup Organization and dmrkynetec (formerly Doane Marketing Research), was conducted in conjunction with national medical specialty societies and other health care professional groups. The physicians surveyed were drawn at random from the AMA Physician Masterfile. In total, more than 7400 health care and medical personnel voluntarily responded to the Survey. For almost every health care and medical specialty surveyed, data were generated from more than 100 respondents. Of the 7403 responses received, 1538 were from non-physician health care professionals, and 5865 were from physicians. Ninety-six of the 5865 physician responses were from physicians specializing in sleep medicine.

The AMA analyzed all physician responses, and the Lewin Group, an independent health care analysis group, analyzed the responses from non-physician health care professionals. Only Survey responses from nonfederal and nonresident physicians working a minimum of 20 hours per week in direct patient care were used to formulate the practice expense per hour (PE/HR) data. Upon receiving the Survey, “respondents were specifically encouraged to seek input from their practice manager or accountant to answer the practice expense questions.”11 The data in the June 2009 PPI Survey primarily reflects respondents’ 2006 financial statements and tax returns.

The data collected by the Survey highlight the commonalities and differences among 51 designated specialties in regard to practice expenses, practice arrangements, practice sizes,
the function of non-physician personnel within a practice, professional medical liability insurance, the use of electronic medical records, debt statistics, age demographics, and participation in government-funded medical insurance and care programs.

**Survey Purpose**

The PPI Survey was conducted to provide the Centers for Medicare and Medicaid Services (CMS) with a basis for updating the practice-expense component of the Medicare Resource-Based Relative Value Scale (RBRVS). Through direct and indirect comparisons of various medical specialties in regard to practice expenses and practice characteristics, the PPI Survey supplies a formative means to help establish an indirect specialty-specific adjustment for current procedural terminology (CPT) codes. The data from the Survey were submitted to CMS on March 21, 2009, and were used, in part, to further calculations used to propose potential 2010 modifications to the Medicare RBRVS, as published in the Federal Register: Proposed Rule Addressing Payment Policies for 2010 (74 FR 33520). Given the baseline nature of the survey data for sleep medicine, as well as the established CMS process for indirect practice expense adjustments for medical specialties previously recognized by CMS, the proposed 2010 payment adjustments do not have a specific effect on sleep medicine.

**SLEEP MEDICINE PRACTICE EXPENSES**

The June 2009 PPI Survey is the first of its kind to identify and include the specialty of sleep medicine. This previously uncharted territory offers new means to analyze and evaluate various elements associated with the practice of sleep medicine. The data provided by the Survey allow, for the first time, a comparison of practice expenses and practice characteristics between sleep medicine and other medical specialties. The statistics derived from the PPI Survey highlight the correlations and surprising differences among related and unrelated medical specialties and subspecialties. The most surprising data are the relationships between medical specialties in regard to their PE/HR. This is especially true for sleep medicine.

The **PE/HR**

The PPI Survey provides data for 13 practice expense categories. These practice expense categories are subdivided into 7 sections within the survey, which, for the purpose of conciseness and clarity, are condensed into 4 larger divisions within this report. These 4 larger divisions and their subsequent practice expense categories include: (1) office expenses; (2) payroll, which includes physician payroll, clerical payroll, clinical payroll (bill independent), and clinical payroll (cannot bill independently); (3) drugs, supplies, and medical equipment, which includes medical supplies, medical supplies (separately billable), drugs, drugs (separately billable), all medical supplies (including drugs, separately billable and not separately billable), and medical equipment; and (4) total PE/HR (less separately billable). Due to the elusive nature of the 13th PE/HR category included in the PPI Survey, “other expenses,” it has been omitted from this analysis. Please note: all practice expenses are averages derived from the responses received for each different specialty.

**PE/HR and Sleep Medicine-Related Specialties**

This section discusses the PE/HR data for sleep medicine as they relate to various medical specialties self-identified in American Academy of Sleep Medicine (AASM) internal data as having a substantial overlap in diagnostic services provided during a given week with self-identified sleep physicians. These specialties include neurology, pulmonary disease, psychiatry, pediatrics, family medicine, and internal medicine and will be referred to as “sleep medicine-related medical specialties.” Even though otolaryngology is typically considered a sleep medicine-related medical specialty, AASM data on self-identified otolaryngologists providing sleep medicine services show that they only provide approximately half (50.5%) of the total diagnostic services provided by a typical sleep physician in a week. Otolaryngologists also are the only surgical specialist physicians who typically provide sleep care services. The PE/HR figures provided by the PPI Survey show a surprising lack of correlation between sleep medicine and these medical specialties of which it is often a sub-specialty. This lack of correlation can be seen through analysis of practice expenses within $1.00 of those spent by sleep physicians.

Of all 13 PE/HR categories included in the PPI Survey, only 2 contain multiple sleep medicine-related specialties with expenses within $1.00 of those reported by sleep medicine specialists. The 2 categories are medical supplies, separately billable (shared by physicians specializing in pulmonary disease, internal medicine, family medicine, pediatrics, and neurology), and drugs, separately billable (shared by physicians specializing in pulmonary disease and psychiatry).

Further study of the correlation between sleep medicine and sleep medicine-related specialties in terms of practice expenses within $1.00 in each of the 13 categories included in the PPI Survey provides the following information:

- Pulmonary disease specialists show this correlation in 3 categories—medical supplies, separately billable; drugs; and drugs, separately billable
- Internal medicine physicians show this correlation in 2 categories—office expenses; and medical supplies, separately billable
- Family medicine physicians show this correlation for medical supplies, separately billable
- Neurologists show this correlation for medical supplies, separately billable
- Pediatricians show this correlation for medical supplies, separately billable
- Psychiatrists show this correlation for drugs, separately billable

Although the similarity in patient care services for sleep medicine and sleep medicine-related medical specialties suggests a logical correlation between practice expenses for these specialties, the PPI Survey shows a surprising lack of formative expense correlation between sleep medicine and its related medical specialties. Of the possible 12 practice expense categories analyzed in this report, sleep medicine-related special-
ties only fell within $1.00 of the PE/HR for sleep medicine in 4 categories: office supplies; medical supplies, separately billable; drugs; and drugs, separately billable. Much of this lack of correlation can be attributed to the unique nature of sleep medicine.

Payroll PE/HR

The following section discusses payroll expenses for sleep medicine as compared with all other medical specialties included in the practice expense portion of the PPI Survey. This analysis is limited to those categories within the payroll practice expense division described earlier.

Sleep medicine practice expenses on nonphysician and clinical payroll are relatively high in comparison with the other 42 medical specialties included in the practice expenses division of the PPI Survey. This level of expense can be attributed, for the most part, to the nonphysician and clinical staff employed by sleep labs (primarily sleep technologists) and the hours when these employees work. Since the hours during which sleep medicine-specialized practice settings are most active for nonphysician staff are typically nocturnal, the expenses accumulated by practices that include sleep medicine testing are logically higher. This is reflected by payroll figures.

The medical specialization most closely related to sleep medicine in terms of PE/PH spent on nonphysician payroll is obstetrics/gynecology. This is a logical correlation, as both specialties may employ populations of uniquely skilled technologists (obstetrics technologists and sleep technologists) and are relatively similar in regard to mean patient care hours per year: 2520.6 for sleep medicine and 2295.1 for obstetrics/ gynecology.

Drugs, Supplies, and Medical Equipment PE/HR

This section provides further information on sleep medicine PE/HR within the categories of drugs, supplies, and medical equipment. Medical equipment practice expenses reported by sleep physicians are higher than those of physicians specializing in sleep-related medical specialties. This reflects the nature of sleep medicine-related testing, which requires patients to be present overnight, as well as the cost of highly sensitive electroencephalographic, electrooculographic, electromyographic, and electrocardiographic instruments and other diagnostic tools. The nature of this type of testing requires sleep labs to provide a reasonable sleep surface, as opposed to a standard examination table, for all patients undergoing nocturnal testing.

In terms of supplies and equipment expenses, the medical specialties most closely related to sleep medicine are spine surgery, radiology, and cardiology. This correlation is logical, as the care provided by these specialists requires the common use of adhesive electrodes, imaging prints, and surgical supplies, (including, but not limited to, gauze, surgical tape, scalpels, surgical masks, suture thread, and other disposable surgical instrumentation). Surgical specialties have closely related practice expenses due to the need for numerous monitors and a sanitized operating suite, which is comparable to the expenses for a sleep medicine testing facility.

Total PE/PH (Less Separately Billable)

Of all 43 medical specialties included in the practice expense portion of the PPI Survey, sleep medicine ranks among the top third most expensive in terms of total PE/HR. The 2 medical specialties with the closest amount of total PE/HR (less separately billable) are obstetrics/gynecology and orthopedic surgery. These 2 medical specialties also share the same 6 most expensive PE/HR categories with sleep medicine. These categories, in descending order, are nonphysician payroll, office expenses, clerical payroll, clinical payroll (cannot bill independently), other expenses, and clinical payroll (can bill independently). Otolaryngology also shares these 6 consecutive categories as its most extensive practice categories. The information discussed in this section, as well as a visual comparison of total PE/HR among these 3 specialties and sleep medicine is shown in Figures 1-3.

Conclusion—PE/HR

Given the unique nature of sleep medicine, the lack of correlation between its practice expenses and those of sleep medicine-related medical specialties is not illogical. Although the similarity between total PE/HR for sleep medicine and obstetrics/gynecology can be largely explained through their similar payroll expenses, the similarity between the other 2 specialties (orthopedic surgery and otolaryngology) and sleep medicine is more difficult to explain. It is logical that orthopedic surgery would have similar total PE/HR to otolaryngology, given the surgical component of both specialties. However, their shared similarity to the total PE/HR reported by sleep physicians, as well as the general trend of expenses for all 3 specialties, is highly illogical, since sleep physicians generally do not perform surgery. Without further data, this similarity cannot be accurately analyzed to form any substantive or formative conclusions. However, the baseline data provided by the PE/HR section of the Survey does identify aspects for further study that may help a sleep practice identify aspects where practice expense savings may be identifiable.

PRACTICE CHARACTERISTICS

In addition to detailed practice expense statistics, the PPI Survey provides information on the practice characteristics of all physicians surveyed across all specialties,7 and sleep medicine.8 The statistics provided on the practice characteristics for all physicians surveyed across all specialties are derived from the mean of all specialties combined. The practice characteristics in both Report I and Report II provide information on the following: practice arrangements; practice size and function of nonphysician personnel; professional medical liability insurance; charity care, Emergency Medical Treatment and Active Labor Act (EMTALA), bad debt, and pay for performance; and contracting and electronic medical records (EMR).

Unlike Report I, Report II provides information on the following: descriptive statistics on hours of work, descriptive statistics for weeks practiced and patient care, ownership and expense level reporting for sample with complete expense data, and comparison of total sample and sample with complete ex-
Table 1 compares the responses from physicians specializing in sleep medicine to those of all physicians surveyed across all specialties on questions regarding practice arrangements.

The first question posed in this section of the PPI Survey was: “What is the primary setting in which you provide most of your patient care services?” Responses to this question found that the majority of both physicians specializing in sleep medicine (36.9%) and of all physicians surveyed across all specialties (32.9%) provide patient care services through a “physician office, single specialty group practice.”

The second question asked “Are you an owner, employee, or independent contractor in your main practice?” The majority (56.5%) of physicians specializing in sleep medicine, as well as of all physicians surveyed across all specialties (61.1%), are either full or part owners in their main practice.

The final question was “Who is your employer” and was only posed to employees and independent contractors. Data collected found that the majority (43.4%) of employed physicians specializing in sleep medicine work for teaching hospitals.

Figure 1 - Similarity of Total PE/HR (Less Separately Billable) Trends:

PE/HR Trend Comparison

<table>
<thead>
<tr>
<th>Expenses</th>
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<tbody>
<tr>
<td>Office expense</td>
</tr>
<tr>
<td>Nonphysician Payroll</td>
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<tr>
<td>Clerical Payroll</td>
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<tr>
<td>Clinical Payroll, Bill Independently</td>
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<tr>
<td>Clinical Payroll, Can’t Bill Independently</td>
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<tr>
<td>Medical Supplies</td>
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<tr>
<td>Medical Supplies, Sep-Billable</td>
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<td>Drugs</td>
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<tr>
<td>Drugs, Sep-Billable</td>
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<tr>
<td>Medical Supplies + Drugs</td>
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<tr>
<td>Medical Equipment</td>
</tr>
<tr>
<td>Total PE/HR (less separately billable)</td>
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Report I: Practice Characteristics of Sleep Medicine as Compared with All Physicians Surveyed Across All Specialties

Report I of the PPI Survey provides information on the practice characteristics reported by all physicians surveyed across all specialties, as well as those reported by sleep physicians. Comparison of the practice characteristics for these 2 groups of physicians provides a better understanding of what is unique about sleep medicine.
The third question posed in this section of the PPI Survey concerned the number of administrative personnel employed by the surveyed physicians’ main practices. Responses to this question found that the majority of both physicians specializing in sleep medicine (44.4%) and of all physicians surveyed across all specialties (46.9%) are in a main practice that employs 1 to 5 administrative personnel.

The fourth and fifth questions posed within this section of the Survey regarded employed clinical staff, characterized in these questions by billing abilities. The fourth question asked: “How many clinical staff who can bill independently are employed in your main practice?” Response data on this question found that the majority of physicians specializing in sleep medicine (60.1%), and of all physicians surveyed across all specialties (65.6%), are in a main practice that does not employ clinical staff who can bill independently. However, 34% of physicians specializing in sleep medicine and 28.7% of all physicians surveyed across all specialties work in a main practice that employs 1 to 5 clinical staff who can bill independently. Responses to the fifth question, “How many clinical staff who cannot bill independently are employed in your main practice,” showed that the majority of physicians...
Professional Medical Liability Insurance

Table 3 compares the responses from sleep physicians with those of all physicians surveyed across all specialties to questions about professional medical liability insurance.

The first question posed in this section of the Survey was: “What type of professional medical liability insurance do you have?” Responses to this question found that the majority of physicians specializing in sleep medicine (96.8%), as well as the majority of physicians surveyed across all specialties (88.9%), are covered by a policy purchased from an insurance carrier (vs self-insured).

The second question regarded tail coverage on “claims-made professional medical liability insurance policies.” Responses to this question found that the majority of both physicians specializing in sleep medicine (87.2%) and all physicians surveyed across all specialties (88.1%) do not have tail coverage on claims-made professional medical liability insurance policies.

The final 2 questions of this section asked about malpractice claims. Responses from these 2 questions found that the majority of both physicians specializing in sleep medicine (57.8%) and all physicians surveyed across all specialties (57.8%) have not had any malpractice claims filed against
all physicians surveyed across all specialties (82.2%) incurred bad debt for services rendered in 2006. The fourth question asked specifically about “bad debt incurred from the provision of EMTALA care mandated in 2006.” Responses to this question found that the majority of both physicians specializing in sleep medicine (77.0%) and of all physicians surveyed across all specialties (94.9%) have not had any malpractice claims filed against them within the past 12 months.

**Charity Care, EMTALA, Bad Debt, and Pay for Performance**

Table 4 provides a visual comparison of the responses from sleep physicians with those of all physicians surveyed on questions regarding charity care, EMTALA, bad debt, and pay-for-performance participation.

The first question of this section of the survey was: “Did you provide charity care in your most recent week of practice?” The majority of both physicians specializing in sleep medicine (95.8%) and of all physicians surveyed across all specialties (94.9%) have not had any malpractice claims filed against them within the past 12 months.

The second question posed was: “Did you provide EMTALA care in your most recent week of practice?” Of the physicians who responded to this question, the majorities of both physicians specializing in sleep medicine (80.4%) and of all physicians surveyed across all specialties (74.0%) stated that they did not provide EMTALA care in their most recent week of practice.

The third and fourth questions of this section concerned bad debt incurred for services rendered in 2006. The majorities of both physicians specializing in sleep medicine (83.1%) and of all physicians surveyed across all specialties (82.2%) incurred bad debt for services rendered in 2006. The fourth question asked specifically about “bad debt incurred from the provision of EMTALA care mandated in 2006.” Responses to this question found that the majority of both physicians specializing in sleep medicine (77.0%) and of all physicians surveyed across all specialties (94.9%) have not had any malpractice claims filed against them within the past 12 months.
Responses to this question found that the majority of both physicians specializing in sleep medicine (86.6%) and of all physicians surveyed across all specialties (79.6%) did not participate in any pay-for-performance programs.

Contracting and EMR

Table 5 provides a comparison of the responses from sleep physicians with those of all physicians surveyed across all specialties on questions regarding the use of contracting and EMR.

The first question in this section asked “How many private health plan contracts does your practice have” and found that the majority of physicians specializing in sleep medicine (30.6%) work in a practice that has 11 to 15 private healthcare coverage contracts, whereas the majority of physicians surveyed across all specialties (26.6%) work in a practice that has 6 to 10 private healthcare coverage contracts.

The second question posed regarded agreement to treat new Medicare patients and found that the majority of both physicians specializing in sleep medicine (86.6%) and of all physicians surveyed across all specialties (79.8%) agree to treat all new Medicare patients, as opposed to some or no new Medicare patients.

The third question asked if the physicians surveyed “agree to treat all, some, or no new Medicaid or S-CHIP patients.” Responses to this question found that the majority of sleep physicians (67.5%), as well as the majority of all physicians surveyed across all specialties (56.1%), agree to treat all new Medicaid or S-CHIP patients.

The final question posed concerned the use of EMR. Responses to this question found that the majorities of both physicians specializing in sleep medicine (36.0%), and of all physicians surveyed across all specialties (24.0%), work in practices that use part paper and part electronic medical records.

Conclusion – Practice Characteristics

In general, the responses to questions posed in the Practice Characteristics section of the PPI Survey show that the practice characteristics of sleep physicians generally do not differ substantially from those of all physicians surveyed across all specialties. However, the key area of divergence relates to personnel associated with a sleep medicine practice.

Breakdown of Sleep Physician Practice Time

Ownership and Expense Level Reporting for Sample with Complete Expense Data

Of the 96 physicians specializing in sleep medicine surveyed by the PPI Survey, 45 provided full practice expense information. In the following comparisons, these 45 sleep medicine physicians serve as a standard of comparison against the total 96 sleep medicine physicians surveyed.

Of these 45 sleep medicine physicians, 33 provided practice expense information on an individual physician level, and 12 provided practice expense information on a specialty or department level. Of the 33 physicians who provided practice expense information on an individual level, 25 are full or part owners of their practice and 8 are employees or independent contractors. Of the 12 physicians who provided practice expense information on a specialty or department level, 9 are full or part owners...
For a visual breakdown of this information, please consult Figure 4.

### Descriptive Statistics for Weeks Practiced and Patient Care Hours for Sleep Medicine

(Based on a survey of 45 physicians specializing in sleep medicine)

Physicians specializing in sleep medicine expend an average of 70.6 total hours working per week. The following information provides a breakdown of how physicians specializing in sleep medicine spend their practice time. In a typical work week, physicians specializing in sleep medicine will spend an average of:

- 27.2 hours seeing patients in their office per week
- 11.0 hours on non-face-to-face medical care per week
- 9.0 hours managing patients in the intensive care unit per week
- 7.5 hours making hospital rounds per week
- 5.2 hours in patient care administrative activities per week
- 3.7 hours on nonpatient care per week
- 2.3 hours on the telephone with patients per week
- 1.9 hours consulting other physicians on patients per week
- 1.2 hours seeing patients in an emergency department per week
- 0.7 hours seeing patients in the operating room per week
- 0.6 hours seeing patients in the patients’ house or home per week
- 0.4 hours emailing patients per week
- 0.0 hours time seeing patients in labor per week

For a visual breakdown of this information, please consult Figure 4.

### SLEEP PHYSICIAN DEMOGRAPHICS

Table 6 provides a comparison of the total sample of sleep physicians with those who responded with complete expense data. The questions posed in this section of the Survey regarded board certification, sex, geographic region of practice, and the population size of their practice area.

Responses to these questions found that the majority of the total sample of physicians specializing in sleep medicine are board certified (89.3%), men (90.8%), reside and work in the South (31.4%), and work in metropolitan areas with populations of 1 million or more (48.5%). Similarly, the majority of sleep physicians able to provide complete expense data are also board certified (84.0%), men (88.5%), reside and work in the...
and obstetrics technologists who typically provide sonography and other services) and the amount of weekly patient care time specialists in both fields provide.

In regard to supplies and equipment expenses, physicians specializing in sleep medicine have practice expenditures most closely akin to those of radiologists, cardiologists, and spine surgeons. Though surprising, these expense similarities may reflect the common use of disposable medical supplies, such as adhesive electrodes, imaging prints, and facility expenses.

Among the most surprising results of the PPI Survey analysis is the similarity of the total PE/HR (less separately billable) of sleep physicians, obstetrics/gynecologists, orthopedic surgeons, and otolaryngologists. Although this similarity is somewhat illogical given the vastly different scopes of practice for these 4 medical specialties, it may be explained by the common use of comparable disposable medical equipment in both sleep medicine and the surgical specialties and by the common employment of uniquely skilled technologists in both obstetrics/gynecology and sleep.

In addition to the conclusions drawn from the practice expense data included in the PPI Survey results, the conclusions that can be formed through analysis of the practice characteristics of physicians specializing in sleep medicine, as compared with those of all physicians surveyed across all medical specialties, are quite surprising. Given the unique nature and practice aspects of sleep medicine, it would be logical to assume that the majority of responses to practice characteristic questions would differ between sleep physicians and all physicians sur-

CONCLUSION

This paper presents baseline information from the PPI Survey that, for the first time, identifies practice expenses and characteristics associated with the practice of sleep medicine. This previously undocumented information offers new means to analyze and evaluate various elements associated with the practice of sleep medicine. The sleep medicine practice expense data provided by the PPI Survey allows a first-time comparison between sleep medicine and other medical specialties, and it identifies a surprising lack of expense correlation between sleep medicine and related medical specialties.

Though the sleep medicine-specific information in the PPI Survey data provided to CMS by the AMA is not expected to have an effect on the Medicare RBRVS, it does provide valuable information for the practice of sleep medicine. Of the conclusions made from the analysis of practice expense data for sleep medicine, as compared with other medical specialties included in the PPI Survey, the most interesting are those dealing with nonphysician and clinical payroll, supplies and equipment expenses, and total practice expenses per week.

In terms of nonphysician and clinical payroll practice expenses, sleep medicine expenses are closest to those of obstetrics/gynecologists. This similarity can be attributed to the employment of technologists by both fields (sleep technologists and obstetrics technologists who typically provide sonography and other services) and the amount of weekly patient care time specialists in both fields provide.

In regard to supplies and equipment expenses, physicians specializing in sleep medicine have practice expenditures most closely akin to those of radiologists, cardiologists, and spine surgeons. Though surprising, these expense similarities may reflect the common use of disposable medical supplies, such as adhesive electrodes, imaging prints, and facility expenses.

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Figure 4 – Breakdown of Work Hours for Sleep Physicians:

South (37.0%), and practice in metropolitan areas with populations of 1 million or more (43.0%).

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veyed across all specialties. However, of the 23 total questions included in the PPI Survey that can be used to compare practice characteristics of sleep medicine and all other medical specialties surveyed, 19 of 23 (82.6%) of the responses from sleep physicians are directly comparable with those compiled from all specialties surveyed.

Of the 4 questions with dissimilar responses, 3 fall under the topic of “practice size and function of non-physician personnel” (“Including you, how many physicians are in your main practice,” “How many non-physician personnel are employed in your main practice,” and “How many clinical staff who cannot bill independently are employed in your main practice”) and the fourth question with a dissimilar response (“How many private health plan contracts does your practice have”) is under the topic of “contracting and electronic medical records.”

Of the 4 practice characteristics questions with dissimilar majority responses, only 2 had responses with significant percentage differences of more than 50%. Both of these questions relate to nonphysician personnel who work in clinical practices. This reflects the role of sleep technologists as an integral part of a sleep medicine practice.

Through the analysis of responses regarding practice characteristics from physicians specializing in sleep medicine, the surprising number of similarities between sleep medicine and all other medical specialties surveyed is undeniable. The relative lack of dissimilarity in practice characteristics questions identified through the PPI Survey demonstrates that sleep medicine has grown into the mainstream of medicine in the course of its young history. The dissimilar aspects, mostly personnel expenses, point to the uniqueness of sleep medicine and contribute to relatively high practice expenses associated with sleep medicine care.

DISCLOSURE STATEMENT

Caroline Blehart has indicated no financial conflicts of interest.

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