

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAYMENTS TO PROVIDERS
FOR POLYSOMNOGRAPHY SERVICES
DID NOT ALWAYS MEET MEDICARE
BILLING REQUIREMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Joanne M. Chiedi
Acting Inspector General**

**June 2019
A-04-17-07069**

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nation-wide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.

Report in Brief

Date: June 2019

Report No. A-04-17-07069

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

From January 1, 2014, through December 31, 2015, Medicare administrative contractors (MACs) nation-wide paid freestanding facilities, facilities affiliated with hospitals, and physicians (collectively referred to as “providers”) approximately \$800 million for selected polysomnography (a type of sleep study to diagnose and evaluate sleep disorders) services. Previous OIG reviews for polysomnography services found that Medicare paid for services that did not meet Medicare requirements. These reviews identified payments for services with inappropriate diagnosis codes, without the required supporting documentation, and to providers that exhibited patterns of questionable billing.

Our objective was to determine whether Medicare made payments to providers for polysomnography services that met Medicare billing requirements.

How OIG Did This Review

Our audit covered \$755 million in Medicare payments to providers for 974,901 beneficiaries with 2 million corresponding lines of polysomnography service on Medicare claims billed using Current Procedural Terminology codes 95810 and 95811. These lines had dates of service in calendar years 2014 and 2015. We reviewed a stratified random sample of 200 beneficiaries with 426 corresponding lines of service with payments totaling \$148,198 during our audit period.

Medicare Payments to Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements

What OIG Found

Some payments that Medicare made to providers for polysomnography services did not meet Medicare billing requirements. Of the 200 beneficiaries that we randomly selected, Medicare made payments to providers for polysomnography services that met Medicare billing requirements for 117 beneficiaries with 276 corresponding lines of service. However, Medicare made payments for the remaining 83 beneficiaries with 150 corresponding lines of service that did not meet Medicare requirements, resulting in net overpayments of \$56,668.

On the basis of our sample results, we estimated that Medicare made overpayments of \$269 million for polysomnography services during the audit period.

These errors occurred because the Centers for Medicare & Medicaid Services (CMS) oversight of polysomnography services was insufficient to ensure that providers complied with Medicare requirements or prevent payment of claims that did not meet those requirements. Without periodic reviews of claims for polysomnography services, MACs were unable to determine whether providers had received payments for claims that did not meet Medicare requirements or to take remedial action.

What OIG Recommends

We recommend that CMS instruct the MACs to recover the portion of the \$56,668 in identified net overpayments that are within the 4-year reopening period. We also recommend that CMS work with the MACs to conduct data analysis allowing for targeted reviews of claims for polysomnography services and educate providers on properly billing for polysomnography services, which could have reduced or eliminated an estimated \$269 million in overpayments over the 2-year audit period. The audit report includes all of the recommendations.

CMS concurred with our recommendations and described actions that it planned to take to address them.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicare Program	1
Polysomnography Services	2
Medicare Coverage of Polysomnography Services.....	3
How We Conducted This Review	4
FINDINGS.....	5
Some Payments to Providers Did Not Meet Medicare Requirements.....	6
Some Providers' Medical Record Documentation Was Incomplete	6
Some Documentation Was Missing or Not Provided	6
Some Attending Technicians or Technologists Lacked Required Credentials or Training Certifications	7
A Provider Received Payments for Duplicative Services	7
A Line of Service Was Incorrectly Coded	7
Oversight of Polysomnography Services Was Insufficient	8
Estimate of Overpayments	8
RECOMMENDATIONS	8
CMS COMMENTS	9
APPENDICES	
A: Audit Scope and Methodology	10
B: Related Office of Inspector General Reports.....	12
C: Federal Requirements Related to Provider Billing for Polysomnography Services.....	13
D: Statistical Sampling Methodology.....	15
E: Sample Results and Estimates.....	17
F: CMS Comments.....	18

INTRODUCTION

WHY WE DID THIS REVIEW

Medicare administrative contractors (MACs) nation-wide paid freestanding facilities, facilities affiliated with hospitals, and physicians (collectively referred to as “providers”) approximately \$800 million for selected polysomnography (a type of sleep study) services provided to Medicare beneficiaries during January 1, 2014, through December 31, 2015 (our audit period).¹ Previous Office of Inspector General (OIG) reviews² of polysomnography services found that Medicare paid for services that did not meet Medicare requirements. These reviews identified payments for services with inappropriate diagnosis codes, without the required supporting documentation, and to providers that exhibited questionable billing patterns. The results of these previous reviews—combined with increased Medicare spending on polysomnography services and growing concerns about fraud, waste, and abuse—prompted us to conduct this review.

OBJECTIVE

Our objective was to determine whether Medicare made payments to providers for polysomnography services that met Medicare billing requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Part B of the Medicare program provides supplementary medical insurance for medical and other health services, including polysomnography services and associated medical supplies. Medicare covers polysomnography services when they are reasonable and medically necessary. The Centers for Medicare & Medicaid Services (CMS) administers Medicare.

During our audit period, CMS contracted with eight MACs³ nation-wide to, among other things, process and pay Medicare Part B claims, conduct reviews and audits, safeguard against fraud and abuse, and educate providers on Medicare billing requirements. As part of claims

¹ These were the most current data available when we began our audit.

² Appendix B contains a list of related OIG reports.

³ Our review included only claims paid by seven of the eight MACs nation-wide because we previously reviewed payments made by First Coast Service Options, Inc. (First Coast), the MAC for Jurisdiction N, for polysomnography services (*First Coast Paid Some Unallowable Sleep Study Claims*, A-04-13-07039, May 2015). See Appendix B: Related Office of Inspector General Reports.

processing, the MACs' responsibilities include implementing certain automated edits, such as system checks to prevent or reduce improper payments by identifying and addressing provider billing errors. These edits flag claim lines for automatic denial or for MAC review to verify that the claim lines are appropriate.

Polysomnography Services

Medicare coverage for polysomnography services includes a diagnostic sleep study and, depending on a beneficiary's diagnosis, may include a positive airway pressure (PAP) titration study. Providers conduct a diagnostic sleep study to diagnose medical conditions that affect sleep, most commonly obstructive sleep apnea (OSA), and to evaluate how effectively PAP devices⁴ manage the beneficiary's condition. During a diagnostic sleep study, the patient sleeps overnight⁵ while connected to sensors that measure and record parameters of sleep, such as brain waves, blood oxygen levels, heart rate, breathing, and eye and leg movements. Primarily, the diagnostic sleep study measures the number of times that a patient either stops breathing or almost stops breathing. A sleep technician or technologist is physically present to supervise the recording during sleep time and can intervene, if needed.

If the diagnostic sleep study indicates that a patient has a sleep disorder, then the provider may conduct a PAP titration study.⁶ Providers use a PAP titration study to calibrate the PAP therapy. In some cases, providers may perform a PAP titration study on the same night as a diagnostic sleep study. Providers refer to this process as a split-night service because they can conduct a PAP titration study when they diagnose OSA within the first few hours of the diagnostic sleep study. If the provider cannot make a diagnosis in the first few hours of the diagnostic sleep study, the beneficiary usually returns another day for a PAP titration study to fit and calibrate the PAP device.

Providers normally perform polysomnography services at sleep disorder clinics,⁷ which may be either freestanding facilities, such as Independent Diagnostic Testing Facilities or provider-owned laboratories, or facilities affiliated with a hospital.

⁴ PAP devices are common treatments used to manage sleep-related breathing disorders such as OSA.

⁵ Most of the patients who undergo testing are not in hospital inpatient status, although they generally stay in a facility overnight.

⁶ During a PAP titration study, providers adjust the PAP device to the appropriate pressure for the beneficiary's condition and fit the PAP for home use.

⁷ Polysomnography providers may also diagnose OSA through sleep testing in the patient's home. Home sleep tests are a type of sleep study used for diagnostic purposes; however, they are not a type of polysomnography service and, therefore, were not included within the scope of our review.

Medicare Coverage of Polysomnography Services

Medicare Part B covers outpatient diagnostic and therapeutic services provided in a hospital outpatient setting or in a freestanding facility. Medicare pays for polysomnography services under the Medicare Physician Fee Schedule when performed in freestanding facilities and under the Outpatient Prospective Payment System (OPPS) when performed in a hospital outpatient department. Providers must use standardized codes, called Current Procedural Terminology (CPT)⁸ codes, to identify the polysomnography service.

All polysomnography services consist of two components: the administration of the test (technical component) and the provider's interpretation of the test (professional component). Providers use modifier code⁹ -TC or -26, respectively, to indicate whether the billing is for the technical or professional component. If a provider does not include a modifier code on the claim, it indicates that the provider is billing for a "global service." A provider that bills for a global service receives payment for both the technical and professional components.¹⁰

When submitting claims to the MAC, providers most commonly bill using CPT code 95810 for sleep disorder diagnostic services. For both full-night PAP titration and split-night services, providers commonly bill using CPT code 95811.

Medicare covers all reasonable and necessary diagnostic tests given for sleep disorders only if the patient has symptoms or complaints such as narcolepsy, OSA, impotence, or parasomnia (*Medicare Benefit Policy Manual* (Manual), chapter 15, § 70.B, Pub. No. 100-02).

Medicare covers diagnostic tests, including polysomnography, only when ordered by the physician treating the beneficiary (42 CFR § 410.32(a); Manual, chapter 15, § 70.A). The provider performing the polysomnography service must retain documentation of the order (42 CFR § 410.32(d)(3)(i); Manual, chapter 15, § 70.A), as well as sufficient information to determine whether payment is due and the amount of payment (42 CFR § 424.5(a)(6)).

⁸ The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2014–2015 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

⁹ A modifier code is a two-digit code reported with a CPT code that provides additional information about the service.

¹⁰ The technical and professional components represent approximately 80 and 20 percent, respectively, of the total or global payment.

Furthermore, most MACs have published local coverage determinations (LCDs)¹¹ regarding polysomnography services that specify that providers must maintain a record of the attending physician's order and the medical record documentation supporting the medical necessity of the services performed.¹²

OIG believes that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).¹³

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$754,534,026 in Medicare payments to providers for 974,901 beneficiaries with 2,056,690 corresponding lines of polysomnography service billed using CPT codes 95810 and 95811.¹⁴ We reviewed a stratified random sample of 200 beneficiaries with 426 corresponding lines of service with payments totaling \$148,198 during our audit period.

We focused our review on CPT codes 95810 and 95811 because of billing errors identified during prior OIG reviews. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹¹ LCDs are decisions that the MACs publish regarding whether to cover a particular item or service within their jurisdictions. LCDs specify under what clinical circumstances an item or service is reasonable and necessary. They contain information to assist providers in submitting correct claims for payment and to provide guidance to the public and medical community within their jurisdictions.

¹² Six of the seven MACs with claims in our target population had LCDs regarding polysomnography that were effective during our audit period and specified that providers must maintain a record of the attending physician's order along with the medical record documentation supporting the medical necessity of services performed (L31846, L34086, L26428, L27530, L32711, L35050, L31718, L33442, L31082, L34535, L24350, L33483, L33663, L34040, L34176, and L34216). Accessed at https://localcoverage.cms.gov/mcd_archive/ on May 31, 2017. We applied the LCDs to claims within the MAC jurisdiction where the provider was located.

¹³ The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

¹⁴ A single Medicare claim from a provider typically includes more than one line of service.

See Appendix A for the details of our scope and methodology, Appendix C for Federal requirements related to provider billing for polysomnography services, and Appendix D for the statistical sampling methodology.

FINDINGS

Some payments that Medicare made to providers for polysomnography services did not meet Medicare billing requirements. Of the 200 randomly selected beneficiaries, Medicare made payments to providers for polysomnography services that met Medicare billing requirements for 117 beneficiaries with 276 corresponding lines of service. However, Medicare made payments for the remaining 83 beneficiaries with 150 corresponding lines of service that did not meet Medicare requirements, resulting in net overpayments of \$56,668.¹⁵ Table 1 lists the types of errors corresponding to those 83 beneficiaries.

Table 1: Errors in Sample Items

Type of Error	Number of Sample Items*
Incomplete Medical Record Documentation	57
Documentation Was Missing or Not Provided	18
Attending Technologist Did Not Have Required Credentials or Training Certification	10
Payments for Duplicative Services	1
Incorrectly Coded Line of Service	1
* A sample item is a Medicare beneficiary. The total exceeds 83 sample items because 4 sample items contained more than 1 type of error.	

On the basis of our sample results, we estimated that Medicare made overpayments of \$269,768,285 for polysomnography services during the audit period. (See Appendix E for our sample results and estimates.)

These errors occurred because CMS oversight of polysomnography services was insufficient to ensure that providers complied with Medicare requirements or prevent payment of claims that did not meet those requirements. Specifically, MACs made improper payments to providers of polysomnography services because they did not perform periodic reviews of claims for polysomnography services or the providers did not understand the Medicare requirements when billing for these services. Without these periodic reviews, MACs were unable to determine whether providers had received payments for claims that did not meet Medicare requirements or to take remedial action.

¹⁵ The value of unallowable lines of service for each type of error does not sum to the sample total because of rounding.

SOME PAYMENTS TO PROVIDERS DID NOT MEET MEDICARE REQUIREMENTS

Of the 200 randomly selected beneficiaries, Medicare made payments to providers for 83 beneficiaries with 150 corresponding lines of service that did not meet Medicare requirements. Of these 83 beneficiaries, 4 had errors in more than 1 category.

Some Providers' Medical Record Documentation Was Incomplete

The Manual (chapter 15, § 70.A) provides that Medicare will cover all reasonable and necessary diagnostic testing for sleep disorders only if the patient has symptoms or complaints such as narcolepsy, OSA, impotence, or parasomnia and all of the following criteria are met:

- the clinic is either affiliated with a hospital or is under the direction and control of physicians;
- patients are referred to the sleep disorder clinic by their attending physicians, and the clinic maintains a record of the attending physician's orders; and
- medical evidence confirms the need for diagnostic testing, e.g., physician examinations and laboratory tests.

Furthermore, most LCDs published by the MACs for polysomnography services specified that providers must maintain a record of the attending physician's order and the medical record documentation supporting the medical necessity of services performed. This documentation includes, but is not limited to, a face-to-face evaluation by the treating physician that documents relevant medical history, signs or symptoms, a physical examination, and results of pertinent diagnostic tests or procedures.

For 57 beneficiaries with 106 corresponding lines of service, providers' documentation was incomplete because it did not contain the face-to-face clinical evaluation, the attending physician's order, or the technician's report. As a result, the providers received overpayments of \$41,599.

Some Documentation Was Missing or Not Provided

Payment to any provider of services or other person is precluded without information necessary to determine the amount due the provider (the Act, § 1833(e)). Additionally, the provider must furnish to the MAC sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

For 18 beneficiaries with 27 corresponding lines of service, providers did not provide any documentation to support the lines of service. For six beneficiaries with eight corresponding lines of service, we contacted the providers multiple times and requested documentation to support the services; however, the providers did not respond to our requests. For the

remaining 12 beneficiaries with 19 corresponding lines of service, the providers stated that they did not have the required supporting documentation. The overpayments associated with services that providers could not support with documentation totaled \$8,340.

Some Attending Technicians or Technologists Lacked Required Credentials or Training Certifications

Some LCDs state that sleep technicians or technologists attending polysomnography services must have appropriate training certifications, such as Registered Polysomnography Technologist or Registered Electroencephalographic Technologist.

For 10 beneficiaries with 14 corresponding lines of service, providers billed for a polysomnography service for which the attending technologists' credentials or training certifications had expired or the provider did not properly document the credentials or certification. As a result of these errors, the providers received overpayments of \$6,300.

A Provider Received Payments for Duplicative Services

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act, § 1862(a)(1)(A)). In addition, the Manual indicates that Medicare does not cover diagnostic testing that duplicates previous testing done by an attending physician, to the extent the results are still pertinent, because such testing is not reasonable and necessary (chapter 15, § 70.A).

For one beneficiary with two corresponding lines of service, providers received Medicare payments for duplicative polysomnography services. The providers performed an additional diagnostic sleep study and the corresponding interpretation for a patient already diagnosed with apnea and receiving PAP therapy. The medical records did not indicate the medical necessity for the additional tests. As a result, the providers received overpayments totaling \$432.

A Line of Service Was Incorrectly Coded

The *Medicare Claims Processing Manual*, Pub. No. 100-04, requires providers to complete claims accurately so that MACs may process them correctly and promptly (chapter 1, § 80.3.2.2) and states that providers must use CPT codes for most outpatient services (chapter 23, § 20.3).

For one beneficiary, a provider billed one polysomnography line of service with an incorrect CPT code. The medical records indicated that the provider performed an interpretation of a PAP titration study (CPT code 95811, modifier code -26), but it incorrectly billed for an interpretation of a diagnostic service (CPT code 95810, modifier code -26). As a result of this error, the provider received an underpayment of \$4.

OVERSIGHT OF POLYSOMNOGRAPHY SERVICES WAS INSUFFICIENT

CMS oversight of polysomnography services was insufficient to ensure that providers complied with Medicare requirements or prevent payment of claims that did not meet those requirements. Specifically, MACs made improper payments to providers of polysomnography services because they did not perform periodic reviews of claims for polysomnography services or the providers did not understand the Medicare requirements when billing for these services.

Officials from the MACs stated that they had not performed any periodic reviews of claims for polysomnography services. However, in cases in which the MACs received referrals from the Unified Program Integrity Contractors (UPICs),¹⁶ post-payment reviews identified providers who consistently billed improperly. The MACs relied on UPIC referrals or the providers' understanding of their LCDs rather than conducting periodic reviews to determine whether Medicare requirements were met. Without these periodic reviews, MACs were unable to determine whether providers had received payments for claims that did not meet Medicare requirements or to take remedial action.

ESTIMATE OF OVERPAYMENTS

As a result of providers billing incorrectly for 150 of 426 lines of polysomnography service for 83 beneficiaries in our sample, MACs made net overpayments of \$56,668. On the basis of our sample results, we estimated that Medicare incorrectly paid \$269,768,285 to providers for polysomnography services during our audit period.

RECOMMENDATIONS

We recommend that CMS:

- instruct the MACs to recover the portion of the \$56,668 in identified net overpayments that are within the 4-year reopening period;¹⁷

¹⁶ The UPICs combine and integrate functions previously performed by the Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs), and Medicaid Integrity Contractors (MICs).

¹⁷ OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services Action Officials. Action Officials at CMS, acting through a MAC or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim that was improper (42 CFR § 405.904(a)(2)). The Medicare Parts A and B appeals process has five levels, including a contractor redetermination, reconsideration by a Qualified Independent Contractor, and decision by the Office of Medicare Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of the appeals process. An overpayment based on extrapolation is re-estimated depending on the results of the appeal.

- instruct the MACs to notify the 117 providers associated with 147 claims (83 beneficiaries with 150 corresponding lines of service) with potential overpayments of \$56,668 so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation;
- work with the MACs to conduct data analysis allowing for targeted reviews of claims for polysomnography services; and
- work with MACs to educate providers on properly billing for polysomnography services, which could have reduced or eliminated an estimated \$269,768,285 in overpayments over the 2-year audit period.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions that it planned to take to address them. CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, appear as Appendix F.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$754,534,026 in Medicare payments for 974,901 beneficiaries with 2,056,690 corresponding lines of polysomnography service billed using CPT codes 95810 and 95811¹⁸ with dates of service from January 1, 2014, through December 31, 2015. We reviewed a stratified random sample of 200 beneficiaries with 426 corresponding lines of service with total payments of \$148,198 during our audit period.

We focused our review on CPT codes 95810 and 95811 because of billing errors identified during prior OIG reviews. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary.

We did not review the overall internal control structure of the MACs or the providers because our objective did not require us to do so. Rather, we limited our review to (1) MACs' internal controls applicable to selected payments and (2) providers' internal controls to prevent incorrect billings. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

From June 2017 through March 2018, we conducted our fieldwork, which included contacting providers associated with the sampled beneficiaries.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted all lines of service data for polysomnography services with CPT codes 95810 and 95811 from CMS's NCH file for the audit period;
- created a sampling frame of 974,901 Medicare beneficiaries with 2,056,690 corresponding lines of service billed for CPT codes 95810 or 95811 during the audit period;
- selected a stratified random sample of 200 beneficiaries (426 lines of service) totaling \$148,198 for detailed review (Appendix D);

¹⁸ The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2014–2015 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

- reviewed available data from CMS’s Common Working File for the lines of service associated with our sampled beneficiaries to determine whether the lines had been canceled or adjusted;
- obtained and reviewed the providers’ billing and medical record documentation to determine whether each line of service was billed correctly;
- calculated overpayment and underpayment amounts for those lines of service that were in error and required adjustment;
- used the results of the sample to estimate the total net Medicare overpayments to providers for polysomnography services for our audit period (Appendix E); and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Sleep Health Center Billed Medicare For Unallowable Sleep Study Services</i>	<u>A-04-14-07053</u>	9/27/2016
<i>International Institute of Sleep, Inc., Billed Medicare for Unallowable Sleep Study Services</i>	<u>A-04-14-07052</u>	6/21/2016
<i>Total Sleep Management, Inc., Billed Medicare For Unallowable Sleep Study Services</i>	<u>A-04-14-07051</u>	10/14/2015
<i>First Coast Service Options, Inc., Paid Some Unallowable Sleep Study Claims</i>	<u>A-04-13-07039</u>	5/14/2015
<i>Questionable Billing for Polysomnography Services</i>	<u>OEI-05-12-00340</u>	10/8/2013

APPENDIX C: FEDERAL REQUIREMENTS RELATED TO PROVIDER BILLING FOR POLYSOMNOGRAPHY SERVICES

FEDERAL LAW AND REGULATIONS

Section 1862(a)(1)(A) of the Act requires that, to be paid by Medicare, a service or an item must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. In addition, the Act precludes payment to any provider of services or other person who fails to furnish information necessary to determine the amount due the provider (the Act, § 1833(e)).

Federal regulations state that the provider must furnish to the MAC sufficient information to determine whether payment is due and the amount of the payment (42 CFR § 424.5(a)(6)).

CENTERS FOR MEDICARE & MEDICAID SERVICES REQUIREMENTS

Chapter 15, section 70, of the Manual says that sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. These clinics may be affiliated with a hospital or a freestanding facility and may provide some diagnostic or therapeutic services, which are covered under Medicare.

This section of the Manual also provides that Medicare will cover all reasonable and necessary diagnostic tests given for sleep disorders only if the patient has symptoms or complaints such as narcolepsy, OSA, impotence, or parasomnia, and all of the following criteria are met:

- the clinic is either affiliated with a hospital or is under the direction and control of physicians;
- patients are referred to the sleep disorder clinic by their attending physicians, and the clinic maintains a record of the attending physician's orders; and
- medical evidence confirms the need for diagnostic testing, e.g., physician examinations and laboratory tests.

Medicare does not cover diagnostic testing that duplicates previous testing done by an attending physician, to the extent the results are still pertinent, because such testing is not reasonable and necessary (chapter 15, § 70.A).

The Manual also states that Medicare may cover therapeutic services for sleep disorders in a hospital outpatient setting or freestanding facility when reasonable and necessary for the patient and when performed under the direct supervision of a physician (chapter 15, § 70.D).

Most MACs have published LCDs¹⁹ regarding polysomnography services that specify that providers must maintain a record of the attending physician's order and the medical record documentation supporting the medical necessity of services performed. This documentation includes, but is not limited to, a face-to-face evaluation by the treating physician that documents relevant medical history, signs or symptoms; a physical examination; and results of pertinent diagnostic tests or procedures. Documentation must be available to the MACs upon request. When the documentation does not meet the criteria for the service rendered or establish the medical necessity of the services, MACs will deny the services as not reasonable and necessary.

The Medicare Claims Processing Manual requires providers to complete claims accurately so that MACs may process them correctly and promptly (chapter 1, § 80.3.2.2) and states that providers must use CPT codes for most outpatient services (chapter 23, § 20.3).

¹⁹ Six of the seven MACs with claims in our target population had LCDs effective during our audit period regarding polysomnography and sleep studies (L31846, L34086, L26428, L27530, L32711, L35050, L31718, L33442, L31082, L34535, L24350, L33483, L33663, L34040, L34176, and L34216). Accessed at https://localcoverage.cms.gov/mcd_archive/ on May 31, 2017.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of nation-wide lines of service paid to providers for polysomnography services provided to Medicare beneficiaries and billed with CPT codes 95810 and 95811 during our audit period.

SAMPLING FRAME

We obtained a database from CMS's NCH data containing all Medicare Part B and hospital outpatient lines of service for polysomnography services billed with CPT codes 95810 and 95811 and performed during calendar years (CYs) 2014 and 2015. This database contained 2,238,465 lines totaling \$811,013,030.

We further refined this database by removing lines:

- corresponding to services paid by First Coast MAC for Jurisdiction N;²⁰
- containing payments corresponding to beneficiaries in the Railroad Retirement Board system;
- corresponding to claims under review by the Recovery Audit Contractor or other entities as of February 14, 2017; and
- with paid amounts of less than \$50.

Removing these lines resulted in a sampling frame of 974,901 Medicare beneficiaries composed of 2,056,690 lines of polysomnography service with a total paid amount of \$754,534,026 from which we drew our sample.

SAMPLE UNIT

The sample unit was a Medicare beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample of 200 Medicare beneficiaries, as follows:

²⁰ We previously reviewed payments made by First Coast for polysomnography services billed with CPT codes 95810 and 95811 during CYs 2011 and 2012 (*First Coast Paid Some Unallowable Sleep Study Claims*, A-04-13-07039, May 2015).

Table 2: Sample Design

Stratum	Medicare Contractor	Beneficiary Count	Total Payments	Sample Size
1	Novitas Solutions, Inc.	252,503	\$203,219,694	35
2	Noridian Healthcare Solutions, LLC	168,099	129,947,579	30
3	Wisconsin Physicians Service Insurance Corp.	163,128	128,331,897	30
4	National Government Services, Inc.	163,330	127,488,944	30
5	Palmetto GBA	97,501	69,837,146	25
6	Cahaba GBA ²¹	79,957	57,584,096	25
7	CGS Administrators, LLC	50,383	38,124,670	25
Total		974,901	\$754,534,026	200

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG Office of Audit Services (OIG/OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units within each stratum, and, after generating the random numbers for each stratum, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments paid to providers nation-wide during the audit period. We also used this software to calculate the lower and upper limits of the two-sided 90-percent confidence interval.

²¹ At the time of our audit, Cahaba GBA administered Medicare Parts A and B claims in Jurisdiction J, but in September 2017, CMS awarded the contract to Palmetto GBA.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Sample Items Containing Overpayments	Value of Overpayments
1	252,503	\$203,219,694	35	\$24,199	14	\$9,521
2	168,099	129,947,579	30	22,464	10	5,668
3	163,128	128,331,897	30	21,381	15	10,074
4	163,330	127,488,944	30	24,411	13	8,082
5	97,501	69,837,146	25	18,218	11	9,196
6	79,957	57,584,096	25	19,830	9	5,248
7	50,383	38,124,670	25	17,695	11	8,879
Total	974,901	\$754,534,026	200	\$148,198	83	\$56,668

Table 4: Estimated Value of Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	\$269,768,285
Lower Limit	223,687,428
Upper Limit	315,849,141



APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 12 2019

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Payments to Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements (A-04-17-07069)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of providing Medicare beneficiaries with access to medically necessary services and, at the same time, protecting the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system and prepayment and postpayment medical reviews. As part of this strategy, CMS recovers identified improper payments in accordance with relevant law and agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for polysomnography services. CMS educates health care providers on Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, a fact sheet of provider compliance tips for polysomnography was published in January 2019¹.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS instruct the MACs to recover the portion of the \$56,668 in identified net overpayments that are within the 4-year reopening period.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contractors to recover the identified overpayments that are within the 4-year reopening period consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that CMS instruct the MACs to notify the 117 providers associated with 147 claims (83 beneficiaries with 150 corresponding lines of service) with potential

¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforPolysomnography-MLN4013531.pdf>

overpayments of \$56,668 so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contractors to notify the identified providers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation

The OIG recommends that CMS work with the MACs to conduct data analysis allowing for targeted reviews of claims for polysomnography services.

CMS Response

CMS concurs with this recommendation. CMS will work with the Medicare Administrative Contractors to conduct data analysis allowing for targeted reviews of claims for polysomnography services.

OIG Recommendation

The OIG recommends that CMS work with the MACs to educate providers on properly billing for polysomnography services, which could have reduced or eliminated an estimated \$269,768,285 in overpayments over the 2-year audit period.

CMS Response

CMS concurs with this recommendation. CMS will continue to work with the Medicare Administrative Contractors to educate providers on properly billing for polysomnography services, including the requirements outlined in local coverage determinations.