



OIG Report of Billing for Polysomnography Services May Lead to Further Scrutiny of Sleep Study Service Providers

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On October 9, 2012, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported the results of its investigation into “Questionable Billing for Polysomnography Services” (“Report”). From 2005 to 2011, Medicare spending on sleep study services increased by 39%, from \$407 million to \$565 million. The Report identified nearly \$17 million in payments for sleep study services that did not meet one or more Medicare requirements, and determined that 180 providers exhibited patterns of questionable billing for the services. Just as the OIG’s December 2010 Report: “Questionable Billing by Skilled Nursing Facilities,” heralded a wave of therapy services investigations, this Report should be viewed as introducing further and future scrutiny of sleep study service providers.

Scope and Plan of the OIG Study

The study on which the Report is based is notable for its comprehensiveness. OIG auditors reviewed all paid claims from hospital outpatient departments and nonhospital providers for polysomnography services (CPT codes 95808, 95810, and 95811) from January 1, 2011, to November 30, 2011, or a total of 626,212 claims totaling \$470 million from 7,232 different providers for 461,363 individual beneficiaries. Where previous OIG studies of “questionable billing” for targeted services have relied upon extrapolation from claims samples, the relatively small number of claims for sleep studies, the limited number of the billing codes, and the narrower scope of the billing requirements allowed the OIG, in this instance, to review the aggregate of the claims for the designated period.

The study is also notable for its design and the methodology by which it identified providers with patterns of questionable billing. The auditors developed eleven measures of questionable billing, which were composed of the three Medicare requirements for billing and eight additional measures “developed in consultation with fraud investigators and sleep medicine professionals.”

The three measures for claims that did not meet Medicare criteria were:

- Inappropriate diagnosis code - claims with inappropriate diagnosis codes per the applicable LCD. Unusually high percentages may indicate billings for services that are not medically necessary.
- Same-day duplicate claims - claims for the same service date as one or more other polysomnography claims for the same beneficiary. Unusually high percentages may be evidence of the submission of duplicate claims.
- Invalid National Provider Identifier (NPI) - claims that were submitted with invalid NPIs. Unusually high percentages may suggest that a provider is billing Medicare inappropriately.

The eight additional measures of questionable billing were developed based on Medicare coverage and billing requirements for sleep study services, measures used in previous OIG questionable-billing studies for other Medicare services, and consultations with fraud investigators and sleep medicine professionals within and outside of OIG.

The eight additional measures suggesting that billings were questionable were:

- Shared beneficiaries - the percentage of a provider's beneficiaries who also had polysomnography claims submitted by one or more other providers. This may be evidence of fraudulent billings using compromised beneficiary numbers.
- Unbundling a split-night service - the percentage of a provider's diagnostic claims for which the provider also submitted a titration claim for the same beneficiary the next day. Providers with unusually high percentages for this measure may be submitting separate claims to increase reimbursement.
- Double-billing for the professional component - the percentage of a provider's claims for global services that had a corresponding claim for the professional component – an indication of possible double-billing.
- Repeated titrations - the percentage of a provider's beneficiaries who had three or more titration claims within a 90-day period – possible evidence of billing for services that are not medically necessary or not rendered.
- Missing professional component - the percentage of a provider's claims for the technical component that had no corresponding claim for the professional component submitted by any provider.
- Titration with no corresponding treatment device - the percentage of a provider's titration claims for which the beneficiary has no corresponding DME claims for PAP devices or oral appliances.
- Missing visit with ordering provider - the percentage of a provider's claims for which the beneficiary had no claims with the ordering provider in the preceding year.
- Repeated polysomnography services - the percentage of a provider's beneficiaries who had two or more polysomnography claims in each of 3 consecutive years.

Having developed the measures of questionable billing for the study, the OIG first identified the claims from all 7,232 providers that did not meet one or more of the three Medicare requirements. The 893 providers with few than three claims were then excluded from the total population, leaving a total of 6,339 providers. The auditors then determined the providers' percentages for each of the eleven measures of questionable billing. For each measure, they identified the providers with unusually high percentages of questionable billing relative to other providers. Finally, they identified providers that had unusually high percentages for three or more of the 11 measures. A pattern of questionable billing was defined as having an unusually high percentage for three or more measures.

Report Findings

The OIG found that, in 2011, Medicare paid almost \$17 million for polysomnography claims that did not meet one or more of the three Medicare requirements. These claims had inappropriate diagnosis codes, were same-day duplicate claims, or were submitted with an invalid NPI. Thirty-five percent of providers with paid claims in 2011 (2,534 providers) submitted at least one claim that did not meet one or more of the three requirements.

A majority of these payments (94%) were for claims with inappropriate diagnosis codes. Eighty-five percent of these claims with inappropriate diagnosis codes came from hospital outpatient departments, and they accounted for \$14 million of the \$16 million paid for these types of improper claims. The OIG noted that this percentage is disproportionately high, since only 53% all 2011 polysomnography claims came from hospital outpatient departments.

Approximately 5.5% were same-day duplicate claims, with 15% of these single claims for multiple polysomnography services for the same beneficiary on the same date of service. This percentage is disproportionately low, since 47% of all 2011 polysomnography claims came from non-hospital providers.

Only a small proportion of improper claims were submitted with an invalid NPI.

Of the 6,339 polysomnography providers whose claims were analyzed, 180 exhibited patterns of questionable billing as defined by the study, accounting for 3.7% of the \$470 million paid for polysomnography services in 2011.

Recommendations

On the basis of its findings, the OIG recommended that CMS:

- Implement claims processing edits or improve existing edits to prevent inappropriate payments for polysomnography services.
- Investigate and recover payments for claims that did not meet Medicare requirements. The Report noted that, in a separate memorandum, the OIG would refer the inappropriate claims it had identified to CMS for “appropriate action.”
- Consider using one or more of the measures of questionable billing in this study to improve safeguards for polysomnography services. In particular, the Report suggested that CMS augment the algorithms in its Fraud Prevention System to identify providers with questionable-billing patterns, and that the eleven measures developed for the study “could be used as screening tools to help CMS select targets for audit or investigation.”
- Refer providers with patterns of questionable billing to contractors for further investigation to determine whether the billing patterns represent inappropriate or fraudulent billing. The Report again noted that, in a separate memorandum, the OIG would refer the providers it had identified as submitting inappropriate claims to CMS for “appropriate action.”

Conclusion

While the Report is careful to emphasize that the eleven measures of questionable billing do not provide conclusive evidence of fraud, the OIG’s recommendations are specifically targeted at preventing future inappropriate claims and toward determining whether past inappropriate claims were, in fact, fraudulent. In the past, “Questionable Billing” studies, where the OIG has used claims analyses to identify questionable scenarios, have led to greater scrutiny of service providers, including civil and criminal False Claims Act investigations. Polysomnography providers should construe the OIG Report as a blueprint for future actions by the OIG and DOJ, as well as CMS.

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