PUBLICATION

OIG Not Asleep at the Switch: Reviews Polysomnography Services from 2011 [Ober|Kaler]

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The OIG recently released its review of polysomnography services (sleep studies) provided in both hospital-based outpatient settings and non-hospital settings. Medicare pays for sleep studies to diagnose obstructive sleep apnea (OSA) and to evaluate the effectiveness of treatment devices like positive airway pressure devices (called a titration study). The review concluded that $16.8 million in Medicare reimbursement for sleep studies did not meet one or more of three Medicare requirements. More importantly for sleep study providers, the OIG reported eight other indicators of questionable or problematic sleep study billing. Polysomnography service providers, both physician-based and hospital-based, should consider these indicators in light of their current billing policies and procedures.

The OIG's study began with a review of the technical component for polysomnography services and global polysomnography services (CPT Codes© 95808, 95810, and 95811) reimbursed by Medicare between January 1 and November 30, 2011. After considering the claims data, local coverage determinations, and advice from government and private sector stakeholders, OIG concluded that 11 indicators indicated questionable or potentially problematic sleep study billing.

Three of the indicators were: (1) claims billed with an inappropriate (or absent) diagnosis code, (2) claims billed with same-day duplicate coding, and (3) claims billed under an invalid or inactive National Provider Identifier. The OIG concluded that claims with any of these three indicators were inappropriately billed to Medicare. Of the three, the inappropriate diagnosis code indicator was responsible for the bulk of the claims, generating $16 million of the $16.8 million in problematic reimbursement. Hospital outpatient sleep study departments submitted 85 percent of the inappropriately billed claims, even though hospital-based sleep providers submitted only half of the claims studied.

The remaining eight indicators were less direct; they either indicated a potentially questionable pattern of billing, were based on Medicare coverage requirements for sleep studies, or were measures used in other questionable billing studies conducted by the OIG. Each indicator is listed below with a short explanation of the billing issue and the type of questionable billing practice indicated.

Indicator	OIG Explanation	Potential Target Provider
Shared beneficiaries	Indicated when beneficiary had received polysomnography services from another provider in 2011	Fraudulent billing by individuals who have stolen beneficiary numbers to submit false claims to Medicare
Unbundling a split-night service	Billed diagnostic sleep study first day and then the titration (fitting of PAP) sleep study on	Providers who should be billing a split-night service (two services in one night) but instead bill the diagnostic test for services before midnight

	second day	and the titration study for the following morning
Double-billing for professional component	Global claims for a sleep study followed by a professional component claim for the same sleep study	Providers double-billing for services
Repeated titrations	Billing for 3 or more titration sleep studies within a 90-day period	Providers billing for titration services that are not rendered or are not medically necessary
Missing professional component	Technical component of sleep study billed but no corresponding professional component billed	Providers billing for services not actually rendered
Titration with no corresponding treatment device	Titration sleep study (for fitting PAP) billed but no corresponding DME claim submitted for PAP or oral appliance	Providers billing for titration services that are not rendered or are not medically necessary
Missing visit with ordering provider	No evidence in Medicare claims data of a visit with the ordering physician in the preceding year	Providers that provide sleep studies without a valid physician order
Repeated polysomnography services	Providers with 2 or more polysomnography services claims in 3 consecutive years	Providers that provide services that are not medically necessary

The OIG also reported that 180 sleep study providers had exhibited patterns of questionable billing in 2011 because they had exhibited an unusually high percentage of at least 3 of the 11 billing indicators. The OIG recommended that these providers' claims be subject to additional scrutiny by CMS.

Ober|Kaler's Comments

The OIG report made much of a 39 percent increase in sleep study reimbursement between 2005 and 2011, even though the $565 million in reimbursement is less significant compared to other services reimbursed by Medicare (for example, Medicare spent $12 billion on hospice services in 2009). Yet, OIG's questionable billing review is significant because it indicates areas of future growth and concern for CMS.

While it is somewhat surprising that 85 percent of the erroneous claims came from hospital-based outpatient sleep studies, OIG suggested this was either because claims processing edits by Medicare Administrative Contractors were more effective against physician-based sleep study providers, or because those physician-based polysomnography providers submitted more appropriately billed claims. Hospital-based outpatient sleep departments should see a short-term increase in rejected claims until their billing staff are accustomed to providing the correct diagnostic codes.

Existing sleep study providers should compare the results of this report to their current policies and procedures and act accordingly. CMS agreed to consider the 11 indicators in its algorithms to detect aberrant billing by questionable providers. Sleep study providers that exhibit these questionable billing practices may have a more likely chance of having their future claims rejected or audited. Lastly, the 180 providers that exhibited a high incidence of questionable billing practices could be subject to a claims review by a CMS contractor even if billing in this manner was appropriate for those providers.