

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**FIRST COAST SERVICE OPTIONS, INC.,  
PAID SOME UNALLOWABLE SLEEP  
STUDY CLAIMS**

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May 2015  
A-04-13-07039

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## EXECUTIVE SUMMARY

*First Coast Service Options, Inc., made some Medicare payments over a 21-month period totaling approximately \$15.7 million for sleep studies that did not meet Medicare requirements.*

### WHY WE DID THIS REVIEW

During 2011 through September 2012, Medicare administrative contractors (MACs) nationwide paid freestanding facilities, facilities affiliated with hospitals, and physicians (providers) approximately \$680 million for selected polysomnography services (a type of sleep study). A previous Office of Inspector General (OIG) review of polysomnography services found that in 2011 Medicare paid nearly \$17 million for services that did not meet certain Medicare requirements (OEI-05-12-00340). That review identified payments for services with inappropriate diagnosis codes and providers that exhibited patterns of questionable billing. Furthermore, in January 2013, a provider agreed to pay \$15.3 million to settle allegations of false polysomnography claims billed to Medicare and other Federal payers. Additionally, prior OIG survey work of polysomnography services found that First Coast Service Options, Inc. (First Coast), the MAC for Jurisdiction 9, paid providers for services that did not comply with Medicare reimbursement requirements. The results of the survey; increased Medicare spending on polysomnography services; and growing concerns about fraud, waste, and abuse prompted us to conduct this review.

The objective of this review was to determine whether payments that First Coast made to providers for polysomnography services were in accordance with Medicare reimbursement requirements.

### BACKGROUND

Polysomnography is a type of sleep study used to diagnose a variety of sleep disorders, most commonly obstructive sleep apnea, and to evaluate a patient's response to therapies such as positive airway pressure. Providers normally perform polysomnographies at sleep disorder clinics, which may be either freestanding facilities, such as independent diagnostic testing facilities or provider-owned laboratories, or facilities affiliated with a hospital.

Providers report the polysomnography services administered to Medicare beneficiaries using standardized codes called Healthcare Common Procedure Coding System codes. The Centers for Medicare & Medicaid Services pays for polysomnography services under the Outpatient Prospective Payment System when performed in a hospital outpatient department and under the Medicare Physician Fee Schedule when performed in freestanding facilities.

During our audit period (January 1, 2011, through September 30, 2012), First Coast was the MAC for Jurisdiction 9, which included Florida, Puerto Rico, and the U.S. Virgin Islands. First Coast paid providers approximately \$48 million for 65,959 beneficiaries with 128,592 corresponding lines of service for selected polysomnography services. We reviewed a random

sample of 100 beneficiaries with 287 corresponding lines of service with total payments of \$120,763 that were potentially at risk for noncompliance with Medicare billing requirements.

## **WHAT WE FOUND**

First Coast made some payments to providers for polysomnography services that were not in accordance with Medicare reimbursement requirements. Of the 100 randomly selected beneficiaries, First Coast made payments to providers for polysomnography services that met Medicare billing requirements for 39 beneficiaries with 127 corresponding lines of service. However, First Coast made payments for the remaining 61 beneficiaries with 160 corresponding lines of service that did not meet Medicare requirements, resulting in overpayments totaling \$67,885.

The 61 beneficiaries with 160 corresponding lines of service had the following deficiencies:

- for 59 beneficiaries with 158 corresponding lines of service, the provider did not have the required supporting documentation, resulting in overpayments totaling \$67,131;
- for 1 beneficiary with 1 corresponding line of service, the attending technologist lacked the proper certification, resulting in an overpayment of \$477; and
- for 1 beneficiary with 1 corresponding line of service, the provider did not use the required modifier code -52, resulting in an overpayment of \$277.

These errors occurred because First Coast did not have adequate claim-processing edits in place to prevent the incorrect payment of Medicare claims or because providers did not understand the Medicare requirements when billing for the services. Furthermore, the Common Working File, the Fiscal Intermediary Standard System, and the Multi-Carrier System had insufficient edits in place to prevent or detect the overpayments.

On the basis of our sample results, we estimated that First Coast overpaid providers \$15,652,912 for polysomnography services during our audit period.

## **WHAT WE RECOMMEND**

We recommend that First Coast:

- recover \$67,885 in identified overpayments;
- strengthen internal controls to ensure that Medicare does not pay for incorrectly billed polysomnography services, specifically by developing and implementing claim-processing edits that would prevent payment of incorrectly billed polysomnography services, which could have resulted in savings totaling \$15,652,912 over a 21-month period; and
- use the results of this audit in its provider education activities.

## **FIRST COAST COMMENTS**

In written comments on our draft report, First Coast concurred with our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	1
The Medicare Program .....	1
Polysomnography Services .....	2
Medicare Billing Requirements for Polysomnography Services .....	3
First Coast Service Options, Inc. ....	4
How We Conducted This Review.....	4
FINDINGS .....	5
Overpayments to Providers.....	6
Incomplete or Missing Documentation.....	6
Attending Technologist Without Required Credentials or Training Certification ..	6
Incorrectly Billed Line of Service Without Modifier Code -52 .....	7
Causes of Incorrect Medicare Payments.....	7
Effect of Incorrect Medicare Payments .....	7
RECOMMENDATIONS .....	7
FIRST COAST COMMENTS .....	8
APPENDIXES	
A: Audit Scope and Methodology .....	9
B: Federal Requirements Related to Medicare Contractor Payment and Provider Billing for Polysomnography Services .....	11
C: Statistical Sampling Methodology .....	13
D: Sample Results and Estimates .....	15
E: First Coast Comments .....	16

## INTRODUCTION

### WHY WE DID THIS REVIEW

Polysomnography is a type of sleep study conducted to diagnose medical conditions that affect sleep. During 2011 through September 2012, Medicare administrative contractors (MACs) nationwide paid freestanding facilities, facilities affiliated with hospitals, and physicians (providers) approximately \$680 million for selected polysomnography services.

A previous Office of Inspector General (OIG) review of polysomnography services found that, in 2011, Medicare paid nearly \$17 million for services that did not meet certain Medicare requirements.<sup>1</sup> That review identified payments for services with inappropriate diagnosis codes and providers that exhibited patterns of questionable billing. Furthermore, in January 2013, a provider agreed to pay \$15.3 million to settle allegations of false polysomnography claims billed to Medicare and other Federal payers.<sup>2</sup> Additionally, prior OIG survey work found that First Coast Service Options, Inc. (First Coast), the MAC for Jurisdiction 9, paid providers for services that did not comply with Medicare reimbursement requirements. The results of the survey; increased Medicare spending on polysomnography services; and growing concerns about fraud, waste, and abuse prompted us to conduct this review.

### OBJECTIVE

The objective of this review was to determine whether payments that First Coast made to providers for polysomnography services were in accordance with Medicare reimbursement requirements.

### BACKGROUND

#### The Medicare Program

Under Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Part B of Medicare provides supplementary medical insurance, including coverage for the cost of polysomnographies. The Centers for Medicare & Medicaid Services (CMS) administers the Part B program and contracts with MACs to, among other things, process and pay claims, conduct reviews and audits, and safeguard against fraud and abuse.<sup>3</sup> MACs must establish and maintain efficient and effective internal controls intended to prevent increased

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<sup>1</sup> *Questionable Billing for Polysomnography Services*, OEI-05-12-00340, October 2013.

<sup>2</sup> U.S. Department of Justice, *Florida-Based American Sleep Medicine to Pay \$15.3 Million for Improperly Billing Medicare and Other Federal Healthcare Programs* (press release). Available online at: [www.justice.gov](http://www.justice.gov). Accessed on February 11, 2014.

<sup>3</sup> Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to MACs.

program costs caused by incorrect or fraudulent payments.<sup>4</sup> MACs use the Common Working File (CWF), the Fiscal Intermediary Standard System (FISS), and the Multi-Carrier System (MCS) to validate providers' claims for outpatient services before paying the claims. MACs calculate the payment for each service using the FISS's Hospital Outpatient Prospective Payment System (OPPS) and MCS's Medicare Physician Fee Schedule (MPFS). These systems can also detect certain improper payments.

## **Polysomnography Services**

Polysomnography is a type of sleep study conducted to diagnose medical conditions that affect sleep, most commonly obstructive sleep apnea (OSA), and to evaluate effectiveness of the use of positive airway pressure (PAP) devices to manage the beneficiary's condition. PAP is a common treatment used to manage sleep-related breathing disorders, including OSA. During a polysomnography, the patient sleeps overnight<sup>5</sup> 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 test measures the number of times that the patient either stops breathing or almost stops breathing. A sleep technician or technologist is physically present to supervise the recording during sleep time and has the ability to intervene if needed.

If the polysomnography indicates that a patient has a sleep disorder, then the provider may conduct a PAP titration study.<sup>6</sup> During a PAP titration study, providers fit and calibrate PAP devices, after which beneficiaries may receive a PAP device for home use. Providers may also prescribe a different type of treatment device, called an oral appliance,<sup>7</sup> instead of a PAP device.

In some cases, providers may perform a PAP titration study on the same night as an in-laboratory sleep study. Providers refer to this process as a split-night service because they can perform this service when they diagnose sleep apnea within the first few hours of the polysomnography. If the provider cannot make a diagnosis early in the polysomnography session, the patient usually returns another day for an additional polysomnography session to fit and calibrate the PAP device.

Providers normally perform polysomnography services at sleep disorder clinics,<sup>8</sup> which may be freestanding facilities, such as independent diagnostic testing facilities or provider-owned laboratories, or facilities affiliated with a hospital.

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<sup>4</sup> CMS, *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, section 10.

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

<sup>6</sup> A PAP titration study is a type of in-laboratory sleep study used to calibrate the PAP therapy. During the titration, the technician adjusts the PAP device to the appropriate pressure for the beneficiary's condition.

<sup>7</sup> An oral appliance is a dental device, similar to an orthodontic retainer or an athletic mouth guard, that helps prevent the soft tissues of the throat from collapsing and obstructing the airway. Doctors typically recommend it for patients with primary heavy snoring, mild OSA, and moderate or severe OSA who cannot tolerate a PAP device.

<sup>8</sup> Polysomnography providers may also diagnose OSA for coverage of a PAP device through home sleep testing.

## Medicare Billing Requirements for Polysomnography Services

Medicare pays for polysomnography services under the OPSS when performed in a hospital outpatient department and under the MPFS when performed in freestanding facilities. Providers must use standardized codes, called Healthcare Common Procedure Coding System (HCPCS)<sup>9</sup> codes, to describe 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 code<sup>10</sup> -TC or -26, respectively, to indicate whether the billing is for the technical or professional component or modifier code -52 to indicate whether the payment involves a partially reduced or eliminated service or procedure. For example, providers append modifier code -52 when the patient is unable to sleep or is intolerant to the PAP device and the technician discontinues the study before completing 6 hours of recording. 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.<sup>11</sup> Providers generally bill separately for the technical and professional components when a different provider performs each component. For example, a freestanding facility would bill for the technical component for performing the study and include a -TC modifier on the claim. The physician who interprets the study then would bill for the professional component and include a modifier code -26 on the claim. However, a freestanding facility that performs and interprets the study would globally bill the services, without including a modifier, or separately bill the services using modifier codes -TC and -26. (The Medicare reimbursement is the same either way.)

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

Ordinarily, a single polysomnography session is sufficient to diagnose adult OSA or to calibrate PAP therapy. The routine use of two polysomnography sessions to diagnose sleep apnea or two sessions to calibrate PAP therapy is generally not reasonable and necessary. Providers need to document persuasive medical evidence justifying the medical necessity for the additional tests if

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<sup>9</sup> HCPCS is a medical code set used throughout the health care industry as a standardized system for describing and identifying health care procedures, equipment, and supplies in health care transactions. HCPCS Level I numerical codes (e.g., 70405) are identical to Current Procedural Technology (CPT) codes that CMS uses when services and procedures involve Medicare beneficiaries. We obtained the five character codes and descriptions included in this report from CPT. The American Medical Association (AMA) developed CPT 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 CPT available from AMA. Applicable Federal Acquisition Regulation and Defense Federal Acquisition Regulation Supplement apply.

<sup>10</sup> A modifier code is a two-digit code reported with a HCPCS code that provides additional information needed to process a claim.

<sup>11</sup> The technical and professional components represent approximately 80 and 20 percent, respectively, of the total or global payment.

they claim more than one each of these types of polysomnography sessions for a single beneficiary (Local Coverage Determination (LCD)).<sup>12</sup> Furthermore, Medicare does not cover diagnostic testing that duplicates previous sleep testing done by an attending physician, to the extent the results are still pertinent, because such testing is not reasonable and necessary (section 1862(a)(1)(A) of the Act).

### **First Coast Service Options, Inc.**

From January 1, 2011, through September 30, 2012 (audit period), First Coast, located in Jacksonville, Florida, was the MAC for Jurisdiction 9, which included Florida, Puerto Rico, and the U.S. Virgin Islands.

### **HOW WE CONDUCTED THIS REVIEW**

During our audit period, First Coast paid providers approximately \$48 million for 65,959 beneficiaries with 128,592 corresponding lines of service for polysomnography services billed using HCPCS codes 95810 and 95811. From a sampling frame of 23,058 beneficiaries, we reviewed a random sample of 100 beneficiaries with 287 corresponding lines of service,<sup>13</sup> totaling \$120,763, that were potentially at risk for noncompliance with Medicare billing requirements. We used computer matching, data mining, and other analytical techniques to identify the line items potentially at risk<sup>14</sup> for noncompliance with Medicare billing requirements. For example, the LCDs indicate that more than two sleep studies per year for the diagnosis of sleep apnea or titration of PAP therapy is usually unnecessary and requires additional justification. The Act indicates that diagnostic testing that is not reasonable and necessary is not covered (section 1862(a)(1)(A) of the Act). CMS guidance specifically provides that diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered because it is not reasonable and necessary under § 1862(a)(1)(A) of the Act (Chapter 15, section 70, of the *Medicare Benefit Policy Manual*). Therefore, we considered services to beneficiaries who received two or more studies during our audit period to be at risk for overpayment because the duplicated diagnostic test may not be reasonable and necessary. We evaluated compliance with billing requirements but did not use medical review to determine whether the services were medically necessary.

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<sup>12</sup> Section 1869(f)(2)(B) of the Act defines LCDs as determinations by a fiscal intermediary or a carrier regarding whether or not a particular item or service is covered on an intermediary- or carrier-wide basis. 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. First Coast published LCDs L29905, L29907, L29949, and L29951 for polysomnography and sleep testing.

<sup>13</sup> A single Medicare claim from a provider typically includes more than one line of service. In this audit, we did not review entire claims; rather, we reviewed specific lines of service billed using HCPCS codes 95810 and 95811.

<sup>14</sup> For purposes of this review, we considered line items for beneficiaries with two or more polysomnography technical components billed using HCPCS codes 95810 or 95811 during our audit period to be at risk for noncompliance with Medicare billing requirements, including services performed by freestanding facilities and hospital outpatient departments.

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.

See Appendix A for the details of our scope and methodology and Appendix B for details on the Federal requirements related to MAC payment and provider billing for polysomnography services.

## FINDINGS

First Coast made some payments to providers for polysomnography services that were not in accordance with Medicare reimbursement requirements. Of the 100 randomly selected beneficiaries, First Coast made payments to providers for polysomnography services that met Medicare billing requirements for 39 beneficiaries with 127 corresponding lines of service. However, First Coast made payments for the remaining 61 beneficiaries with 160 corresponding lines of service that did not meet Medicare requirements, resulting in overpayments totaling \$67,885.

The 61 beneficiaries with 160 corresponding lines of service had the following deficiencies:

- for 59 beneficiaries with 158 corresponding lines of service, the provider did not have the required supporting documentation, resulting in overpayments totaling \$67,131;
- for 1 beneficiary with 1 corresponding line of service, the attending technologist lacked the proper certification, resulting in an overpayment of \$477; and
- for 1 beneficiary with 1 corresponding line of service, the provider did not use the required modifier code -52,<sup>15</sup> resulting in an overpayment of \$277.

These errors occurred because First Coast did not have adequate claim-processing edits in place to prevent the incorrect payment of Medicare claims for polysomnography services or because the providers did not understand the Medicare requirements when billing for these services. Furthermore, the CWF, the FISS, and the MCS had insufficient edits in place to prevent or detect the overpayments.

On the basis of our sample results, we estimated that First Coast overpaid providers \$15,652,912 for polysomnography services during our audit period. See Appendix C for our statistical sampling methodology and Appendix D for our sample results and estimates.

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<sup>15</sup> Providers use modifier code -52 to indicate partial reduction or discontinuation of a service.

## **OVERPAYMENTS TO PROVIDERS**

### **Incomplete or Missing Documentation**

Section 1833(e) of the Act precludes payment to any provider of services or other person who does not provide information necessary to determine the amount due the provider. Additionally, 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)). Furthermore, the LCDs state that, before any sleep testing, the patient must have a face-to-face clinical evaluation by the treating physician that must include, among other requirements, a physical examination that documents body mass index, neck circumference, and a focused cardiopulmonary and upper airway evaluation.

For 59 beneficiaries with 158 corresponding lines of service, the providers did not have the required supporting documentation as follows:

- For 141 lines of service, providers had missing documentation for the initial face-to-face clinical evaluation, the attending physician's orders, the technician's report, or the interpretation report.
- For 12 lines of service, providers included documentation for a face-to-face clinical evaluation that was incomplete because it did not record the patient's body mass index or neck circumference.
- For three lines of service, a provider billed for services for which it did not provide supporting documentation.
- For two lines of service, we could not locate the billing provider, so we were unable to obtain supporting documentation. The attending physician, who referred the beneficiary for these two polysomnography services, stated that he neither had records of these completed studies nor billed for the corresponding interpretations.

As a result of these errors, the providers received overpayments totaling \$67,131.

### **Attending Technologist Without Required Credentials or Training Certification**

The 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 one beneficiary (one line of service), a provider billed for a polysomnography service for which the attending technologist lacked the appropriate credentials or training certification. As a result of this error, the provider received an overpayment of \$477.

## **Incorrectly Billed Line of Service Without Modifier Code -52**

The *Medicare Claims Processing Manual* (Manual) requires providers to complete claims accurately so that MACs may process them correctly and promptly (chapter 1, section 80.3.2.2). The Manual also directs providers to use modifier code -52 to indicate partial reduction or cancellation of services (Chapter 4, section 20.6.4).

For one beneficiary (one line of service), a provider incorrectly billed without using the required modifier code -52. The medical records indicated that PAP calibration failed because of the patient's inability to sleep because he suffered from restless legs syndrome. Because the patient was unable to sleep, the provider did not perform a complete polysomnography study. As a result of this error, the provider received an overpayment of \$277.

## **CAUSES OF INCORRECT MEDICARE PAYMENTS**

First Coast made improper payments to providers of polysomnography services because it did not have adequate claim-processing edits in place to prevent the incorrect payment of Medicare claims or because the providers did not understand the Medicare requirements when billing for these services. First Coast did not detect these errors because the edits flagged only duplicate payments. Furthermore, the CWF, the FISS, and the MCS had insufficient edits in place to prevent or detect the overpayments. These systems apply certain edits to claims received and return claims that do not pass these edits to the providers. Examples include claims that have invalid health insurance claim and provider numbers.

## **EFFECT OF INCORRECT MEDICARE PAYMENTS**

As a result of providers billing incorrectly for 160 of 287 line items of polysomnography services in our sample, First Coast made overpayments totaling \$67,885 in Medicare Part B and OPSS claims.

On the basis of our sample results, we estimated that First Coast incorrectly paid \$15,652,912 to providers for polysomnography services during our audit period.

## **RECOMMENDATIONS**

We recommend that First Coast:

- recover \$67,885 in identified overpayments;
- strengthen internal controls to ensure that Medicare does not pay for incorrectly billed polysomnography services, specifically by developing and implementing claim-processing edits that would prevent payment of incorrectly billed polysomnography services, which could have resulted in savings totaling \$15,652,912 over a 21-month period; and
- use the results of this audit in its provider education activities.

## **FIRST COAST COMMENTS**

In written comments on our draft report, First Coast concurred with our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

First Coast's comments are included in their entirety as Appendix E.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

From January 1, 2011, through September 30, 2012 (audit period), First Coast paid providers approximately \$48 million for 65,959 beneficiaries with 128,592 corresponding lines of service for selected polysomnography services. We reviewed 287 of these paid lines of service, totaling \$120,763, pertaining to 100 randomly sampled beneficiaries.

Our review focused on whether First Coast met Medicare reimbursement requirements when paying providers for polysomnography services. We evaluated individual providers' compliance with medical documentation requirements but did not use medical review to determine whether the services were medically necessary, except for a limited review performed by First Coast.

We did not review the overall internal control structure of First Coast or the providers because our objective did not require us to do so. Rather, we limited our review to (1) First Coast's internal controls applicable to the 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.

We conducted our fieldwork from May through August 2013, which included contacting First Coast in Jacksonville, Florida, and providers that received the selected Medicare payments during our audit period.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with First Coast staff to gain an understanding of its procedures for the processing and payment of claims for polysomnography services;
- used CMS's NCH file to identify the lines of service for polysomnography services with HCPCS codes 95810 and 95811 paid by First Coast during the audit period;
- identified 66,724 lines of service corresponding to 23,058 Medicare beneficiaries with 2 or more lines of service billed for HCPCS codes 95810 or 95811 or both during the audit period;
- selected a random sample of 100 beneficiaries (287 lines of service) totaling \$120,763 for detailed review (Appendix C);
- reviewed available data from CMS's CWF for the lines of service associated with our sampled beneficiaries to determine whether the lines had been canceled or adjusted;

- requested that the providers associated with our sampled beneficiaries furnish documentation to support the polysomnography services billed, including the:
  - requisition for service or attending physician's orders,
  - technician's report, and
  - interpreting physician's report (if applicable);
- reviewed the providers' documentation to determine whether each line of service was billed correctly;
- requested that First Coast's medical review staff review the providers' documentation, to validate our findings, for a limited quantity of the sample items that we determined did not meet the documentation requirements for billing for polysomnography services;
- calculated overpayment amounts for those lines of service requiring adjustments;
- estimated the total overpayments to providers of polysomnography services (Appendix D); and
- discussed the results of our review with First Coast 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: FEDERAL REQUIREMENTS RELATED TO MEDICARE CONTRACTOR PAYMENT AND 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 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)). Medicare Part B provides coverage for outpatient diagnostic and therapeutic services provided in a hospital outpatient setting or in a freestanding facility. Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered because it is not reasonable and necessary under section 1862(a)(1)(A) of the Act.

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)).

### **CMS GUIDANCE**

Chapter 15, section 70, of the *Medicare Benefit Policy Manual*, Pub. No. 100-02, provides that all reasonable and necessary diagnostic testing for sleep disorders is covered only if the patient has symptoms or complaints such as narcolepsy, sleep apnea, impotence, or parasomnia; and 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
- the need for diagnostic testing is confirmed by medical evidence, e.g., physician examinations and laboratory tests.

The *Medicare Benefit Policy Manual* also states that therapeutic services for sleep disorders may also be covered in a hospital outpatient setting or in a freestanding facility when reasonable and necessary for the patient and performed under the direct supervision of a physician.

Furthermore, LCDs<sup>16</sup> published by the MACs for polysomnography and sleep testing specify additional coverage requirements. For example, among other requirements, before any sleep

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<sup>16</sup> LCDs are decisions published by a MAC on whether to cover a particular item or service on a MAC-wide basis. The LCDs specify under what clinical circumstances an item or service is considered to be 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. First Coast published LCDs L29905, L29907, L29949, and L29951 for polysomnography and sleep testing.

testing, the patient must have a face-to-face clinical evaluation by the treating physician that must include at a minimum:

- the patient's sleep history and symptoms;
- an Epworth sleepiness scale;<sup>17</sup> and
- a physical examination that documents body mass index, neck circumference, and a focused cardiopulmonary and upper airway evaluation.

The LCDs also indicate that, ordinarily, a single polysomnography session is sufficient either to diagnose OSA or to calibrate PAP therapy. If a provider claims more than one polysomnography diagnostic testing session, the LCD requires persuasive medical evidence justifying the medical necessity for the additional tests. Further, the routine use of more than one polysomnography session to calibrate PAP therapy would not be considered reasonable and necessary.

Additionally, the LCDs require that sleep technicians or technologists attending polysomnography services have appropriate personnel certifications, such as Registered Polysomnography Technologist or Registered Electroencephalographic Technologist.

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

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<sup>17</sup> The Epworth Sleepiness Scale is a scale intended to measure daytime sleepiness with a very short questionnaire. This questionnaire can help diagnose sleep disorders.

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The population consisted of Medicare claims for polysomnography services with HCPCS codes 95810 and 95811 with dates of service during our audit period. CMS added these Medicare claims to its NCH database as of September 30, 2012.

### SAMPLING FRAME

We obtained two databases of claims from CMS's NCH data containing Part B and hospital outpatient line items for polysomnography services billed with HCPCS codes 95810 and 95811 performed from January 1, 2011, through September 30, 2012, with paid amounts greater than zero. The Part B database contained 797,453 beneficiaries with 1,266,729 lines totaling \$354,580,785, and the hospital outpatient database contained 453,017 beneficiaries with 617,916 lines totaling \$325,072,204.

We extracted all line items corresponding to First Coast and combined them into a single database consisting of 65,959 beneficiaries with 128,592 lines totaling \$47,551,441. We further refined the database by removing:

- 218 lines containing payments corresponding to beneficiaries under the Railroad Retirement Board system,
- 45,392 lines with modifier code -26 (professional component),
- 2,627 lines with paid amounts less than \$400,
- 5 lines corresponding to claims under review by the Recovery Audit Contractor, and
- 32,358 lines corresponding to beneficiaries associated with only 1 line of polysomnography service.

This resulted in a sampling frame of 23,058 Medicare beneficiaries with 2 or more lines of polysomnography services that providers billed using a technical component, from which we drew our sample. The beneficiaries in our sampling frame were associated with 66,724 lines of polysomnography services totaling \$27,237,837. Of these 66,724 lines, 18,732 included modifier code -26 and paid amounts less than \$400 that corresponded with beneficiaries that we identified as having 2 or more lines of polysomnography services that providers billed with a

technical component. Because these 18,732 lines were associated with these beneficiaries, we added the beneficiaries back into our sampling frame.<sup>18</sup>

### **SAMPLE UNIT**

The sample unit was a Medicare beneficiary.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

The sample consisted of 100 Medicare beneficiaries.

### **SOURCE OF RANDOM NUMBERS**

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

### **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the sample units in the frame from 1 to 23,058. After generating 100 random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the dollar value of the overpayments.

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<sup>18</sup> In our effort to identify which beneficiaries received polysomnography services with 2 or more technical components, we originally removed from our sampling frame the beneficiaries associated with all 48,019 line items with modifier code -26 and paid amounts less than \$400 because these line items typically were associated with only 1 polysomnography service. After identifying the beneficiaries in this group of line items that still had 2 or more polysomnography services, we added back into the sample frame the beneficiaries associated with 18,732 line items containing 2 or more services with a professional component and paid amounts less than \$400 that corresponded with the beneficiaries initially identified.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**SAMPLE RESULTS**

<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Overpayments</b>	<b>Value of Overpayments</b>
23,058	\$27,237,837	100	\$120,763	61	\$67,885

**ESTIMATES**

**Estimated Value of Overpayments for the Audit Period**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	\$15,652,912
Lower limit	13,341,893
Upper limit	17,963,931



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**Sandy Coston**  
**CEO & President**  
First Coast Service Options, Inc.  
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March 11, 2015

Ms. Lori S. Pilcher, Regional Inspector General  
Office of Inspector General  
Office of Audit Services, Region IV  
61 Forsyth Street, SW, Suite 3T41  
Atlanta, GA 30303

**Reference: A-04-13-07039**

Dear Ms. Pilcher:

We received the U.S. Department of Health & Human Services, Office of Inspector General (OIG) draft report entitled, "*First Coast Service Options, Inc., Paid Millions in Unallowable Sleep Study Claims*" and reviewed the findings and recommendations. We appreciate the opportunity to review and provide comments prior to release of the final report.

First Coast respectfully requests that OIG revise the title of the report to read "*First Coast Service Options, Inc., Overpaid Unallowable Sleep Study Claims*"

In the draft report, you outlined three recommendations that we have addressed as follows:

**Recommendation:**

Recover \$67,885 in identified overpayments.

**Response:**

First Coast concurs with OIGs recommendation regarding actual overpayment recoupments. Upon receipt of the specific overpaid claim information, First Coast Debt Recovery will pursue recovery of any overpayments.

**Recommendation:**

Strengthen internal controls to ensure that Medicare does not pay for incorrectly billed polysomnography services, specifically by developing and implementing claim processing edits that would prevent payment of incorrectly billed polysomnography services, which could have resulted in savings totaling \$15,652,912 over a 21-month period.

**Response:**

First Coast concurs with OIGs recommendation regarding increased prepayment editing for these services. First Coast has existing automated diagnosis to procedure code editing in place based on the Jurisdiction N Local Coverage Determination for these services. As a result of data analysis, four providers identified as drivers of the utilization for these services were subjected to provider specific probe medical reviews in 2013. As a result of high probe error rates, these providers were placed on provider specific prepayment medical review. First Coast will evaluate current data to determine the potential impact to the claims payment error rate and Trust Fund dollars at risk for these services to determine the appropriate level of prepayment intervention.

**Recommendation:**

Use the results of this audit in its ongoing provider education activities.

**Response:**

First Coast concurs with OIGs recommendation regarding enhanced education for sleep studies. First Coast will evaluate current data trends to determine if one-on-one provider specific education or widespread education is appropriate.

Again, we appreciate the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding our responses, please contact Mr. Gregory W. England at (904) 791-8364.

Sincerely,



Sandy Coston

cc: Gregory W. England