

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PENINSULA REGIONAL MEDICAL
CENTER: AUDIT OF MEDICARE
PAYMENTS FOR POLYSOMNOGRAPHY
SERVICES**

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**March 2021
A-04-19-07087**

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: March 2021

Report No. A-04-19-07087

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



Why OIG Did This Audit

Medicare administrative contractors nationwide paid approximately \$885 million for selected polysomnography (a type of sleep study) services provided to Medicare beneficiaries from January 1, 2017, through December 31, 2018 (audit period). Previous OIG audits of polysomnography services found that Medicare paid for some services that did not meet Medicare requirements. These audits identified payments for services with inappropriate diagnosis codes, without the required supporting documentation, and to providers that exhibited questionable billing patterns. After analyzing Medicare claim data, we selected for audit Peninsula Regional Medical Center (Peninsula), a hospital provider located in Salisbury, Maryland.

Our objective was to determine whether Medicare claims that Peninsula submitted for polysomnography services complied with Medicare requirements.

How OIG Did This Audit

Our audit covered \$2.9 million in Medicare payments to Peninsula for 1,018 beneficiaries associated with 1,564 lines of polysomnography service billed using Current Procedural Terminology codes 95810 and 95811. We reviewed a stratified random sample of 100 beneficiaries who received polysomnography services (169 lines of service) with payments totaling \$317,826 during our audit period.

Peninsula Regional Medical Center: Audit of Medicare Payments for Polysomnography Services

What OIG Found

Peninsula submitted Medicare claims for some polysomnography services that did not comply with Medicare billing requirements. Of the 100 randomly selected beneficiaries, Peninsula submitted Medicare claims for polysomnography services that complied with Medicare billing requirements for 90 beneficiaries associated with 157 lines of service. However, Peninsula submitted Medicare claims for the remaining 10 beneficiaries associated with 12 lines of service that did not comply with Medicare requirements, resulting in net overpayments of \$17,499.

On the basis of our sample results, we estimated that Peninsula received overpayments of at least \$66,647 for polysomnography services provided during the audit period.

The errors occurred because Peninsula's policies and procedures did not address the processing of Medicare claims for polysomnography services to ensure that services billed to Medicare were adequately documented and coded correctly.

What OIG Recommends and Peninsula Comments

We recommend that Peninsula Regional Medical Center: (1) refund to the Medicare program the estimated \$66,647 overpayment for claims that it incorrectly billed; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and (3) implement policies and procedures to ensure that Medicare claims for polysomnography services comply with Medicare requirements.

In written comments on our draft report, Peninsula concurred with our findings and recommendations and described actions that it had taken to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare administrative contractors (MACs) nationwide paid freestanding facilities, facilities affiliated with hospitals, and physicians (collectively referred to as “providers”) approximately \$885 million for selected polysomnography (a type of sleep study) services provided to Medicare beneficiaries from January 1, 2017, through December 31, 2018 (our audit period).¹ Previous Office of Inspector General (OIG) audits² of polysomnography services found that Medicare paid for some services that did not comply with Medicare requirements. These audits 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 audits—combined with increased Medicare spending on polysomnography services and growing concerns about fraud, waste, and abuse—prompted us to conduct additional audits.

After analyzing Medicare claim data for our audit period, we selected several providers for audit based on Medicare Part B payments to the providers. This report covers one of those providers, Peninsula Regional Medical Center (Peninsula), a hospital provider located in Salisbury, Maryland.

OBJECTIVE

Our objective was to determine whether Medicare claims that Peninsula submitted for polysomnography services complied with Medicare 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 and contracts with MACs to, among other things, process and pay Medicare Part B claims, conduct reviews and

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

² Appendix B contains a list of related OIG reports.

audits, safeguard against fraud and abuse, and educate providers on Medicare billing requirements.

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 devices³ manage the beneficiary's condition. During a diagnostic sleep study, the patient sleeps overnight⁴ 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.⁵ 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,⁶ which may be either freestanding facilities, such as Independent Diagnostic Testing Facilities or provider-owned laboratories, or facilities affiliated with a hospital.

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

³ PAP devices are common treatments used to manage sleep-related breathing disorders such as OSA.

⁴ Most of the patients who undergo testing are not in hospital inpatient status, although they generally stay in a facility overnight.

⁵ 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.

⁶ 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.

under the Outpatient Prospective Payment System when performed in a hospital outpatient department. Providers must use standardized codes, called Current Procedural Terminology (CPT)⁷ 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 generally bill separately for the technical and professional components when each is performed by a different provider; some providers may perform only one component of the service. Hospital outpatient departments can receive payment only for the technical component.

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

Furthermore, most MACs have published local coverage determinations (LCDs)⁸ that specify coverage requirements for polysomnography. LCD L35050, in effect in Maryland during our audit period,⁹ says that Medicare covers all reasonable and necessary diagnostic tests given for

⁷ The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2017–2018 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.

⁸ 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.

⁹ Novitas Solutions, Inc., the MAC for Jurisdiction L, had two consecutive versions of LCD L35050 in effect during our audit period that set forth coverage requirements for polysomnography and sleep studies. They were substantively the same for our purposes, except as noted. Accessed at https://localcoverage.cms.gov/mcd_archive/ on April 6, 2020.

sleep disorders only if the patient has symptoms or complaints of narcolepsy, OSA, impotence,¹⁰ or parasomnia.

The LCD also specifies 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.

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.¹¹

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.¹²

Peninsula Regional Medical Center

Peninsula is a hospital provider located in Salisbury, Maryland. Novitas Solutions, Inc., its MAC, paid Peninsula approximately \$2.9 million¹³ for 1,018 beneficiaries associated with 1,564 lines of polysomnography service billed using CPT codes 95810 and 95811 provided in calendar years (CYs) 2017 and 2018 on the basis of CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS AUDIT

Our audit covered approximately \$2.9 million in Medicare payments to Peninsula for 1,018 beneficiaries associated with 1,564 lines of polysomnography service billed using CPT codes

¹⁰ The version of LCD L35050 in effect from the beginning of the audit period through March 7, 2018 did not mention impotence as a covered indication for polysomnography. The version in effect from March 8, 2018 to the end of the audit period mentioned impotence as a covered indication for polysomnography. Novitas Solutions, Inc. indicated that there was no coverage change from one version to the next. Accordingly, we included impotence as a covered indication for polysomnography for the entire audit period.

¹¹ The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

¹² 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

¹³ Actual payments were \$2,903,858.

95810 and 95811.¹⁴ We reviewed a stratified random sample of 100 beneficiaries who received polysomnography services (169 lines of service) with payments totaling \$317,826 during our audit period.

We focused our audit on CPT codes 95810 and 95811 because of billing errors identified during prior OIG audits. 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.

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

Peninsula submitted Medicare claims for some polysomnography services that did not comply with Medicare billing requirements. Of the 100 randomly selected beneficiaries, Peninsula submitted Medicare claims for polysomnography services that complied with Medicare billing requirements for 90 beneficiaries associated with 157 lines of service. However, Peninsula submitted Medicare claims for the remaining 10 beneficiaries associated with 12 lines of service that did not comply with Medicare requirements, resulting in net overpayments of \$17,499.¹⁵ Table 1 lists the types of errors corresponding to those 10 beneficiaries.

Table 1: Errors in Sample Items

Type of Error	Number of Sample Items*
Incomplete Medical Record Documentation	6 (8 lines of service)
Incorrectly Coded Lines of Service	3 (3 lines of service)
Billed Service Not Provided	1 (1 line of service)
* A sample item is a Medicare beneficiary.	

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

¹⁵ This amount includes underpayments totaling \$506.

On the basis of our sample results, we estimated that Peninsula received overpayments of at least \$66,647 for polysomnography services provided during the audit period. (See Appendix E for our sample results and estimates.)

The errors occurred because Peninsula's policies and procedures did not address the processing of Medicare claims for polysomnography services to ensure that services billed to Medicare were adequately documented and coded correctly.

PENINSULA SUBMITTED CLAIMS FOR SOME POLYSOMNOGRAPHY SERVICES THAT DID NOT COMPLY WITH MEDICARE REQUIREMENTS

Of the 100 randomly selected beneficiaries, Peninsula submitted Medicare claims for polysomnography services for 10 beneficiaries associated with 12 lines of service that did not comply with Medicare requirements.

Medical Record Documentation Was Incomplete

The LCD provides that Medicare will cover all reasonable and necessary diagnostic testing for sleep disorders only if the patient has symptoms or complaints of 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, the LCD 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, physician examinations and results of laboratory tests. The LCD also stated that every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.

For 6 beneficiaries (8 lines of service), Peninsula's documentation was incomplete because the face-to-face clinical evaluation from the attending physician did not document the need for testing (6 lines of service) or the attending physician's orders did not include the date, signature, or name of the referring physician (2 lines of service). As a result, Peninsula received overpayments of \$15,222.

Services Were Incorrectly Coded

The LCD requires providers to complete claims with CPT codes that describe the services performed. The HCPCS and CPT Codebook directs providers to use modifier code¹⁶ -52 if the test was terminated prior to recording at least 6 hours of sleep or in cases of reduced services as appropriate.

For two beneficiaries (2 lines of service), Peninsula billed incorrect CPT codes. The medical records indicated that Peninsula performed an interpretation of a PAP titration study (CPT code 95811), but it incorrectly billed for a diagnostic service (CPT code 95810). For one beneficiary (one line of service), Peninsula incorrectly billed without using the required modifier code -52. The medical record indicated that the attending technician attempted a split-night study after 2 hours of diagnostic testing, but the patient could not tolerate the mask and chose to end the study prematurely. As a result of these three errors, Peninsula received a net overpayment of \$375.¹⁷

Peninsula Submitted a Claim for a Service That It Did Not Provide

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)).

For one beneficiary (one line of service), Peninsula submitted a claim for a PAP titration study (CPT code 95811) that it did not provide. The medical record indicated that the patient refused the study; therefore, the study was cancelled, and the patient returned to his hospital room to continue his inpatient stay. As a result, Peninsula received an overpayment of \$1,902.

PENINSULA DID NOT HAVE POLICIES AND PROCEDURES FOR POLYSOMNOGRAPHY SERVICES

Although Peninsula had some policies and procedures, they did not address the processing of Medicare claims for polysomnography services to ensure that services billed to Medicare were adequately documented and coded correctly.

ESTIMATE OF OVERPAYMENTS

Of the 100 randomly selected beneficiaries, Peninsula submitted Medicare claims for polysomnography services for 10 beneficiaries associated with 12 lines of service that did not

¹⁶ A modifier code is a two-digit code reported with a CPT code that provides additional information about the service.

¹⁷ Two lines of service resulted in underpayments totaling \$506 and one line resulted in an \$881 overpayment.

comply with Medicare requirements, resulting in net overpayments of \$17,499. On the basis of our sample results, we estimated that Peninsula received overpayments of at least \$66,647 for polysomnography services during our audit period.

RECOMMENDATIONS

We recommend that Peninsula Regional Medical Center:

- refund to the Medicare program the estimated \$66,647 overpayment for claims that it incorrectly billed;¹⁸
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule,¹⁹ and identify any of those returned overpayments as having been made in accordance with this recommendation; and
- implement policies and procedures to ensure that Medicare claims for polysomnography services comply with Medicare requirements.

PENINSULA COMMENTS

In written comments on our draft report, Peninsula concurred with our findings and recommendations and described actions that it had taken to address them. Peninsula's comments appear as Appendix F.

¹⁸ OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

¹⁹ This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$2,903,858 in Medicare payments to Peninsula for 1,018 beneficiaries associated with 1,564 lines of polysomnography service billed using CPT codes 95810 and 95811²⁰ with dates of service from January 1, 2017, through December 31, 2018 (audit period). We reviewed a stratified random sample of 100 beneficiaries who received polysomnography services (169 lines of service) with total payments of \$317,826 during our audit period.

We focused our audit on CPT codes 95810 and 95811 because of billing errors identified during prior OIG audits. 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 Peninsula because our objective did not require us to do so. Rather, we limited our review to Peninsula's internal controls to prevent incorrect billings for polysomnography services. 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 audit from October 2019 through September 2020.

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 1,018 Medicare beneficiaries associated with 1,564 lines of service billed for CPT codes 95810 or 95811 during the audit period;
- selected for detailed review a stratified random sample of 100 beneficiaries who received polysomnography services (169 lines of service) with payments totaling \$317,826 (Appendix D);

²⁰ The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2017–2018 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 Peninsula’s supporting 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 Peninsula for polysomnography services for our audit period (Appendix E); and
- discussed the results of our audit with Peninsula 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>Medicare Payments To Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements</i>	<u>A-04-17-07069</u>	6/7/2019
<i>Sleep Health Center Billed Medicare For Some 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

LCD L35050²¹ published by the MAC specifies coverage requirements regarding polysomnography. The LCD 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.

The LCD also provides that Medicare will cover all reasonable and necessary diagnostic tests given for sleep disorders only if the patient has symptoms or complaints of narcolepsy, OSA, impotence,²² 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.

²¹ Novitas Solutions, Inc., the MAC for Jurisdiction L, had two consecutive versions of LCD L35050 in effect during our audit period that set forth coverage requirements for polysomnography and sleep studies. They were substantively the same for our purposes, except as noted. Accessed at https://localcoverage.cms.gov/mcd_archive/ on April 6, 2020.

²² The version of LCD L35050 in effect from the beginning of the audit period through March 7, 2018 did not mention impotence as a covered indication for polysomnography. The version in effect from March 8, 2018 to the end of the audit period mentioned impotence as a covered indication for polysomnography. Novitas Solutions, Inc. indicated that there was no coverage change from one version to the next. Accordingly, we included impotence as a covered indication for polysomnography for the entire audit period.

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 under section 1862 (a)(1)(A) of the Act.

The LCD 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.

The LCD further specifies that providers must maintain all documentation in the patient's medical record, and the medical record must support the medical necessity of services performed. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient. 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. Additionally, the provider must submit CPT codes that describe the services performed.

The HCPCS and CPT Codebook directs providers to use modifier code -52 if the test was terminated prior to recording at least 6 hours of sleep or in cases of reduced services as appropriate.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of lines of service paid to Peninsula 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 outpatient lines of service for polysomnography services billed with CPT codes 95810 and 95811 and performed during CYs 2017 and 2018. This database contained 1,564 lines totaling \$2,903,858.

We then compared all of the lines of service to the claims in the Recovery Audit Contractor (RAC) Data Warehouse and found that none of the lines of service were on any claims that were selected for review by another contractor or had been previously excluded from the RAC Data Warehouse.

We grouped these lines by beneficiary (using corresponding Health Insurance Claim Numbers) which resulted in a sampling frame of 1,018 Medicare beneficiaries composed of 1,564 lines of polysomnography service with a total paid amount of \$2,903,858 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 100 Medicare beneficiaries, as follows:

Table 2: Sample Design

Stratum	Description	Beneficiary Count	Total Payments	Sample Size
1	Beneficiaries with two or more polysomnography services	491	\$1,938,501	67
2	Beneficiaries with one polysomnography service	527	965,357	33
Total		1,018	\$2,903,858	100

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 Peninsula during the audit period. We also used this software to calculate a point estimate and a two-sided 90-percent confidence interval.

To be conservative, we recommend recovery of overpayments at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total in the sampling frame 95 percent of the time.

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 Errors	Net Value of Overpayments
1	491	\$1,938,501	67	\$255,526	5	\$12,346
2	527	965,357	33	62,300	5	5,153
Total	1,018	\$2,903,858	100	\$317,826	10	\$17,499

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

Point estimate	\$172,762
Lower limit	66,647
Upper limit	\$278,877