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

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

Why OIG Did This Review

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

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

How OIG Did This Review

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

What OIG Found

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

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

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

What OIG Recommends

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

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