PROVIDER COMPLIANCE TIPS FOR POLYSOMNOGRAPHY (SLEEP STUDIES)

PROVIDER TYPES AFFECTED

Physicians and other practitioners who write prescriptions for polysomnography

BACKGROUND

An Office of the Inspector General, U.S. Department of Health & Human Services (HHS), study completed in October 2013 found Medicare spending for polysomnography services rose from $407 million to $565 million, an increase of 39 percent, from 2005 to 2011.[1]

REASONS FOR DENIAL

Medicare paid nearly $17 million for polysomnography services that did not meet one or more of three Medicare requirements. Payments for services with inappropriate diagnosis codes composed a majority of these payments. About 85 percent of claims with inappropriate diagnosis codes came from hospital outpatient departments.

The Centers for Medicare & Medicaid Services (CMS) requires an order from the provider who treats the beneficiary for all diagnostic tests, including polysomnography. Polysomnography providers must enter the name and National Provider Identifier (NPI) of this ordering provider on the polysomnography claim. Polysomnography services performed at hospital outpatient departments must be ordered by a provider who does not have a financial relationship with the hospital, as specified by the statutes regarding self-referral.[1]

Coverage of polysomnography is limited to diagnoses of narcolepsy, sleep apnea, impotence, and parasomnia; which must be documented in the medical record. Polysomnography for chronic insomnia is not covered.[2]

TO PREVENT DENIALS

For polysomnography to be covered by Medicare, health care professionals must meet the following criteria:

- The clinic is either affiliated with a hospital or is under the direction and control of physicians. Diagnostic testing routinely performed in sleep disorder clinics may be covered even in the absence of direct supervision by a physician.
- Patients are referred to the sleep disorder clinic by their attending physicians, and the clinic maintains a record of the attending physician's orders.
- The need for diagnostic testing is confirmed by medical evidence (for example, physician examinations and laboratory tests).
- 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.[2]

1 US Inspector General Report (OEI-05-12-00340)
2 Medicare Benefit Policy Manual, Chapter 15, Section 70

RESOURCES

FOR MORE INFORMATION ABOUT...	RESOURCE
Office of the Inspector General, U.S. Department of Health & Human Services (HHS), Questionable Billing for Polysomnography Services	https://oig.hhs.gov/oei/reports/oei-05-12-00340.asp
Medicare Benefit Policy Manual, Chapter 15, Section 70	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html

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