

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PAID  
\$22 MILLION IN 2012 FOR  
POTENTIALLY  
INAPPROPRIATE  
OPHTHALMOLOGY CLAIMS**



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## **EXECUTIVE SUMMARY: MEDICARE PAID \$22 MILLION IN 2012 FOR POTENTIALLY INAPPROPRIATE OPHTHALMOLOGY CLAIMS OEI-04-12-00281**

### **WHY WE DID THIS STUDY**

Medicare paid approximately \$8.2 billion in 2012 to screen for, diagnose, evaluate, or treat cataracts, wet age-related macular degeneration (wet AMD), and glaucoma. Medicare uses a combination of national and local coverage requirements to determine whether it will cover services for these conditions. However, recent investigations have found that some ophthalmology services for these conditions are vulnerable to fraud, waste, and/or abuse.

### **HOW WE DID THIS STUDY**

We reviewed Medicare claims data from 2012 and identified approximately 49 million claims that 46,456 providers submitted for screening for, diagnosing, evaluating, or treating cataracts, wet AMD, and glaucoma. We also reviewed the Medicare coverage database and identified 4 national requirements and 2 local coverage requirements that specified when Medicare should and should not cover certain ophthalmology procedures associated with these conditions. Then we analyzed these claims to identify those that were potentially paid inappropriately based on these requirements. We did not review the medical records for any claims to determine if exceptions to the requirements were documented and appropriate. We also calculated the total amount that Medicare paid each provider for these claims, and we determined which contractor paid these claims.

### **WHAT WE FOUND**

Medicare paid \$22 million for ophthalmology claims in 2012 that were potentially inappropriate, according to national and local coverage requirements. Specifically, \$14 million was paid despite the presence of national requirements that were designed to prevent these payments. Similarly, \$8 million was paid despite the presence of local coverage requirements that were designed to prevent these payments. Additionally, two of eleven Medicare contractors paid a disproportionate amount of the potentially inappropriate Medicare payments.

### **WHAT WE RECOMMEND**

We recommend that the Centers for Medicare & Medicaid Services (CMS) (1) implement additional claims processing edits or improve existing edits to ensure claims are paid appropriately and (2) determine the appropriateness of ophthalmology claims identified in this report and take appropriate action. CMS concurred with both of our recommendations.

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## OBJECTIVE

To determine the extent to which Medicare payments for ophthalmology claims in 2012 were potentially inappropriate.

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## BACKGROUND

In 2012, Medicare paid approximately \$8.2 billion for all services that screen for, diagnose, evaluate, or treat cataracts, wet AMD, and glaucoma.<sup>1</sup> Recent investigations have found that certain ophthalmology services are vulnerable to fraud, waste, and/or abuse. For example, in 2011, an ophthalmologist in Philadelphia was convicted for submitting \$4.5 million in fraudulent claims, most of which were for diagnostic or evaluation services. Additionally, in 2013, an ophthalmologist in New Jersey was convicted of reusing single-use vials of Lucentis, an expensive ophthalmology biologic, from 2008 to 2009.

### **Medicare Requirements for Ophthalmology Services**

Medicare uses a combination of national and local coverage requirements to determine whether certain ophthalmology services are covered. National requirements are created at the Federal level and apply to all Medicare beneficiaries and claims processing contractors.<sup>2</sup> In the absence of specific national requirements, claims processing contractors may create their own local coverage requirements about what services to cover. The most common local coverage requirements are local coverage determinations (LCDs), which are contractor decisions about whether to cover particular services in their respective jurisdictions.<sup>3</sup> Medicare may still pay for claims that do not meet the specifications outlined in national or local coverage requirements if additional documentation adequately explains the medical need for the claim.

Medicare covers procedures to screen for, diagnose, evaluate, or treat many eye conditions. However, the three eye conditions for which Medicare pays the most each year are cataracts, wet AMD, and glaucoma.

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<sup>1</sup> Medicare Part B covers ophthalmology services provided by licensed specialists, including ophthalmologists and optometrists. Social Security Act, § 1832(a)(1); Centers for Medicare & Medicaid Services (CMS), *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 15, § 30.4. Medicare claims identify the specialties of providers by using codes for those specialties.

<sup>2</sup> Social Security Act, §§ 1862(a)(1)(A), 1862(l), 1869 (f)(1)(B); CMS, *Medicare National Coverage Determinations Manual*, Pub. No. 100-03, Foreword.

<sup>3</sup> Social Security Act, §§ 1862(a)(1)(A), 1862(l), 1869(f)(2)(B); CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 13, § 13.1.3. A single claims processing contractor may be responsible for more than one jurisdiction and apply a single LCD across more than one of its jurisdictions.

In 2012, Medicare paid approximately \$8.2 billion to screen for, diagnose, evaluate, or treat these conditions.

Cataracts. Medicare paid approximately \$3.5 billion in 2012 for services that screen for, diagnose, evaluate, or treat cataracts, the leading cause of blindness in the world.<sup>4</sup> Medicare covers many services that diagnose or evaluate cataracts. However, it has a national requirement stating that it will not routinely cover more than one comprehensive eye examination and scan for beneficiaries whose only diagnosis was cataracts.<sup>5</sup>

Medicare also covers several services that treat cataracts, including cataract surgeries. Cataract surgeries remove the poorly functioning natural lens of an eye and replace it with a synthetic lens. It is medically impossible to perform more than one cataract surgery on the same eye because an eye's natural lens will never grow back. Medically impossible services should be denied as not being reasonable and necessary.

Wet AMD. Medicare paid approximately \$2.2 billion in 2012 for services that screen for, diagnose, evaluate, or treat wet AMD. This disease is the leading cause of severe vision loss in people over age 65 in the United States. Medicare covers several services that diagnose or evaluate wet AMD, including fluorescein angiographies,<sup>6</sup> but it does not have any national requirements that place specific limits on these services. However, some claims processing contractors have LCDs limiting the number of these diagnostic or evaluation services for which a provider may bill annually.<sup>7</sup>

Medicare also covers several services that treat wet AMD, with the most common being the injection of the biologic Lucentis, which goes directly into the eye. In 2012, Medicare paid an average of \$2,013 for each full Lucentis injection. Medicare does not have a national requirement specifically limiting this injection; however, the claims processing contractors for six jurisdictions have LCDs specifying that Lucentis

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<sup>4</sup> National Institutes of Health, "Leading Causes of Blindness," *NIH Medline Plus*. Volume 3, Number 3, Summer 2008.

<sup>5</sup> CMS, *National Coverage Determinations Manual*, Pub. No. 100-03, ch. 1, § 10.1. Claims for additional exams are denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional exam is fully documented.

<sup>6</sup> Fluorescein angiography is an eye test that uses a special dye and camera to look at blood flow in the retina and choroid, the two layers in the back of the eye.

<sup>7</sup> For example, L27584 states that fluorescein angiographies are considered medically necessary no more than nine times per eye per year and that claims exceeding this frequency will be suspended and reviewed for medical necessity. CMS, *Local Coverage Determination (LCD) for Ophthalmic Angiography (Fluorescein and Indocyanine Green) (L27584)*, Palmetto GBA. These requirements indicate that the additional exams are denied as not reasonable and necessary unless the medical need for the additional exams is fully documented.

injections are not covered more frequently than once per month per eye.<sup>8</sup> To support the monthly limit on Lucentis injections, these LCDs cite the Food and Drug Administration (FDA)-approved dosing guidelines on the biologic's label. The FDA guidelines state that injections should be administered between once monthly and once every 3 months.<sup>9</sup>

Another service that treats wet AMD, ocular photodynamic therapy, is a process with two steps. These steps are billed separately, but they must be performed within 30 minutes of one another.<sup>10</sup> Because both steps must be performed for the procedure to work properly, Medicare has a national requirement stating that it covers each step only when both steps are performed on the same date.<sup>11</sup>

*Glaucoma.* Medicare paid approximately \$1.3 billion in 2012 for services that screen for, diagnose, evaluate, or treat glaucoma, which is a leading cause of blindness in the United States.<sup>12</sup> A national requirement states that Medicare covers either of two types of screening services once every 12 months for beneficiaries at high risk for glaucoma.<sup>13</sup>

### **Medicare Claims Processing Contractors**

CMS uses contractors to process and pay for services provided to beneficiaries in the Medicare program.<sup>14</sup> The scope of each claims processing contract covers a specific jurisdiction (e.g., States) and one or more claim type. Claim types include Part A claims, Part B claims, durable medical equipment, and home health and hospice claims. Some of these contractors are awarded and administer multiple contracts.

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<sup>8</sup> Three claims processing contractors, responsible for six jurisdictions, have a total of three LCDs specifying limitations on Lucentis injections. The LCDs indicate that the additional Lucentis injections are denied as not reasonable and necessary unless the medical need for the additional injections is fully documented.

<sup>9</sup> FDA, *Lucentis® (ranibizumab injection) Intravitreal Injection*, Initial US Approval: 2006. US BLA (BL125156) Ranibizumab Injection. For example, CMS, *Local Coverage Determination (LCD) for Ranibizumab (Lucentis) (L29266)*, First Coast Service Options, Inc., June 14, 2011.

<sup>10</sup> FDA, *Visudyne™ (verteporfin for injection) US package insert*, April 7, 2000.

<sup>11</sup> CMS, *National Coverage Determinations Manual*, Pub. No. 100-03, ch. 1, § 80.2.

<sup>12</sup> National Institutes of Health, "Leading Causes of Blindness," *NIH Medline Plus*. Volume 3, Number 3, Summer 2008.

<sup>13</sup> CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 15, § 280.1.

<sup>14</sup> CMS has completed the process of replacing all other claims processing contractor types, which included fiscal intermediaries, carriers, and regional home health intermediaries, with Medicare Administrative Contractors (MAC). Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, expanded CMS's authority to contract with entities such as MACs.

The primary goal of each claim processing contractor is to appropriately process and pay Medicare claims.<sup>15</sup> Because of the large number of claims that contractors must process, they cannot manually review every claim submitted by providers. Instead, contractors take two main types of actions to prevent inappropriate payments: (1) medical review of selected claims and (2) provider outreach and education. Medical review actions include identifying claims for review and determining whether they meet Medicare coverage criteria, implementing automated prepayment edits,<sup>16</sup> and developing local coverage requirements. Provider outreach and education is provided through a variety of media, such as articles, conference calls, and Web-based training.<sup>17</sup>

### **Related OIG Work**

OIG has previously found vulnerabilities in Medicare payments for ophthalmology services.<sup>18</sup> For example, OIG found that Medicare inappropriately paid \$97.6 million in 2005 for evaluation and management services that were paid separately from global eye surgeries.<sup>19</sup>

Other OIG work has found that Medicare paid providers substantially more for treating wet AMD with the expensive biologic Lucentis instead of other biologic treatments that are similarly effective.<sup>20</sup> For example, OIG found that in 2008 and 2009, Medicare Part B would have saved \$1.1 billion if it had reimbursed all Lucentis injections at the rate of a cheaper alternative biologic.<sup>21</sup>

Additionally, OIG is currently conducting a study to identify and describe providers with questionable billing for ophthalmology services from

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<sup>15</sup> CMS, *Medicare Fee-for-Service 2011 Improper Payments Report*, p. 6. Accessed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/2011-Medicare-FFS-Improper-Payment-Report-.pdf> on September 3, 2014.

<sup>16</sup> “Edits” are coded into the claims payment system to automatically deny all or part of a claim or suspend all or part of a claim for manual review. CMS, *Medicare Program Integrity Manual*, ch. 3. § 3.2, and ch. 7. § 7.2.8.1.

<sup>17</sup> CMS, *Medicare Contractor Beneficiary and Provider Communications Manual*, ch. 6. § 20.

<sup>18</sup> OIG, *Fletcher Allen Health Care Did Not Always Bill Correctly for Evaluation and Management Services Related to Eye Injection Procedures*, A-01-11-00515, May 2012; OIG, *Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services*, OEI-09-06-00430, August 2009.

<sup>19</sup> OIG, *Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005*, A-05-07-00077, April 2009.

<sup>20</sup> OIG, *Medicare Payments for Drugs Used to Treat Wet Age-Related Macular Degeneration*, OEI-03-10-00360, April 2012.

<sup>21</sup> OIG, *Review of Medicare Part B Avastin and Lucentis Treatments for Age-Related Macular Degeneration*, A-01-10-00514, September 2011.

2012.<sup>22</sup> The report will also determine the extent to which Lucentis was billed to Medicare in 2012.

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## METHODOLOGY

### Data Collection and Analysis

We analyzed claims data for ophthalmology services to identify those that Medicare potentially paid inappropriately based on national or local coverage requirements. Each Medicare-allowed amount is composed of the Medicare Part B responsibility (80 percent) and the beneficiary's responsibility (20 percent).<sup>23</sup> Throughout this report, when we refer to the dollar amount that Medicare "paid" for each service, we are referencing the Medicare-allowed amount for each service.

We analyzed 100 percent of paid claims for ophthalmology services in 2012 from CMS's National Claims History (NCH) Carrier File. This included approximately 49 million paid claims billed by 46,456 providers in 2012. Additionally, because Medicare covers glaucoma screening services only once every 12 months for beneficiaries at high risk for glaucoma, we analyzed 100 percent of paid claims for glaucoma screening exams in 2011 from NCH. This included 24,772 paid claims billed by 847 providers in 2011.

*National Requirements.* To determine which claims were potentially paid inappropriately, according to four national requirements, we analyzed all ophthalmology claims data to identify those for:

- (1) additional cataract diagnostic tests billed as being performed in 2012, for beneficiaries whose only diagnosis was cataracts and who had already had cataract diagnostic tests in 2012;
- (2) additional cataract surgeries billed for the same eye in the same year;
- (3) ocular photodynamic therapy to treat wet AMD in which both steps of the treatment were not billed as being performed on the same date; or
- (4) glaucoma screening tests billed for beneficiaries who had already been screened for glaucoma within the previous 12 months (including 2011 claims, as needed).

We determined the number of claims billed with these characteristics, and we calculated the total amount that Medicare paid each provider for claims with these characteristics. We also determined which contractors paid claims with these characteristics.

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<sup>22</sup> OEI-04-12-00280, in progress.

<sup>23</sup> Medicare Part B also required a deductible of \$99.90 per month in 2012.

Local Coverage Requirements. We first reviewed claims processing contractors' LCDs to identify requirements regarding services that screen for, diagnose, evaluate, or treat cataracts, wet AMD, and glaucoma. We identified 21 LCDs, all of which concerned services related to wet AMD.<sup>24</sup> For each of these LCDs, we identified the unique limits stated in the LCD. For example, some LCDs allowed up to four fluorescein angiographies per eye per year, while others allowed up to nine. We also identified the dates when the LCDs were active, the contractor jurisdictions that were using those LCDs, and the providers in those jurisdictions.

To determine which claims were potentially paid inappropriately, according to local coverage requirements, we limited our analysis to only those claims to which the LCDs applied.<sup>25</sup> We identified claims with these characteristics:

- 1) Lucentis injections to treat wet AMD that were billed more frequently than the LCD-established limits (28 days), or
- 2) tests to diagnose wet AMD that were billed more frequently than LCD-established limits.

We determined the number of claims billed with these characteristics, and we calculated the total amount that Medicare paid each provider for claims with these characteristics. We also determined which contractors paid each of these claims.

### **Limitations**

We did not review medical records for any claims in this report. Some claims for cataract diagnostic exams, wet AMD diagnostic exams, or Lucentis injections may have had documentation supporting the need for these procedures and, therefore, would be allowable by the national or local coverage requirement.

### **Standards**

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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<sup>24</sup> See Appendix A for the list of 21 LCDs and the dollar amount of claims that Medicare potentially paid inappropriately.

<sup>25</sup> OEI-04-12-00280, in progress, will determine the extent to which providers bill unusually high for Lucentis injections and tests to diagnose wet AMD in jurisdictions without these LCDs.

## FINDINGS

### **Medicare paid \$22 million for potentially inappropriate ophthalmology claims in 2012**

According to national and local coverage requirements, Medicare paid approximately \$22 million for potentially inappropriate ophthalmology claims in 2012. Medicare paid these claims despite national or local coverage requirements that were designed to prevent their payment. Overall, two of eleven contractors paid a disproportionate amount of this \$22 million for ophthalmology claims.

In total, Medicare paid 46,456 providers for all services to screen for, diagnose, evaluate, or treat cataracts, wet AMD, and glaucoma in 2012. Almost all of these providers received either no potentially inappropriate Medicare payments (74 percent) or received less than \$9,999 in potentially inappropriate Medicare payments (25.5 percent). Table 1 provides the number and percentage of providers by dollar ranges of potentially inappropriate Medicare payments for ophthalmology claims.

<b>Dollar Ranges of Payments for Claims</b>	<b>Number of Providers</b>	<b>Percentage of Providers</b>
\$0	34,383	74.0%
\$1–\$999	7,677	16.5%
\$1,000–\$9,999	4,159	9.0%
\$10,000–\$99,999	225	0.5%
\$100,000 or more	12	<0.1%
<b>Total</b>	<b>46,456</b>	<b>100%</b>

Source: OIG analysis of NCH file.

For example, 12 providers received between \$100,000 and \$1.5 million for ophthalmology claims that were potentially inappropriate in 2012. Among these 12 providers, all received payments that local coverage requirements were designed to prevent, but only 1 received payments that national requirements were designed to prevent. Fourteen percent (\$3 million of \$22.3 million) of the total amount Medicare potentially paid inappropriately was for claims submitted by these 12 providers.

### ***Medicare paid \$14 million for ophthalmology claims that were potentially inappropriate according to national requirements***

Medicare paid \$14.3 million in 2012 for 68,837 ophthalmology claims despite national requirements designed to prevent payment for these claims. These four national requirements concerned ophthalmology services that screen for, diagnose, evaluate, or treat cataracts, wet AMD, and glaucoma in 2012. Table 2 shows the payment amount, number of

claims, and number of providers by the four national requirements we analyzed.

<b>National Requirement</b>	<b>Medicare Payment*</b>	<b>Number of Claims</b>	<b>Number of Providers**</b>
Claims for additional cataract surgeries for the same eye in 2012	\$8,564,392	10,560	4,548
Claims for additional cataract diagnostic tests for beneficiaries whose only diagnosis was cataracts and who had already had cataract diagnostic tests in 2012	\$5,223,294	52,547	8,501
Claims for glaucoma screening tests for beneficiaries more than once within a 12-month period	\$322,175	5,055	266
Claims for ocular photodynamic therapy to treat wet AMD in which both steps of treatment were not billed as performed on the same day in 2012	\$228,755	675	269
<b>Total</b>	<b>\$14,338,012</b>	<b>68,837</b>	<b>11,168</b>

Source: OIG analysis of 2012 NCH file.

\*Column does not sum to total due to rounding.

\*\*Column does not sum to total because some providers had potentially inappropriate claims across multiple national requirements.

It is medically impossible to have more than one cataract surgery per eye because the initial surgery removes the eye’s lens. However, Medicare paid approximately \$8.6 million for 10,560 cataract surgeries on eyes that already had a cataract surgery in 2012. Ninety-three percent of providers (4,221 of 4,548) billing for additional cataract surgeries on the same eye in 2012 did so for 5 or fewer claims. However, 7 providers billed for 20 or more cataract surgeries for eyes that already had cataracts removed in 2012, and Medicare paid these 7 providers a combined total of \$172,340 for such surgeries. This includes one provider whom Medicare paid \$59,455 for 69 surgeries—the most of any provider—on eyes that already had cataracts removed.

Also, Medicare does not routinely cover more than one cataract diagnostic test for patients whose only diagnosis is cataracts. However, Medicare paid approximately \$5.2 million for 52,547 cataract diagnostic exams on beneficiaries whose only diagnosis was cataracts and who had already had a cataract diagnostic exam and scan in 2012. The majority of providers (7,930 of 8,501) that billed for this type of exam did so for fewer than 20 diagnostic claims in 2012. However, Medicare paid one provider \$20,108 for 260 additional cataract diagnostic services, the most of any provider.

***Medicare paid \$8 million for ophthalmology claims that were potentially inappropriate according to local coverage requirements***

Medicare paid \$7.9 million in 2012 for 25,583 ophthalmology claims despite the presence of 21 LCDs, which stated that these claims should not have been paid. These LCDs covered two types of coverage requirements

regarding services that diagnose or treat wet AMD. Table 3 shows the payment amount, number of claims, and number of providers by the two requirements we analyzed. Also, see Appendixes A and B for the number and dollar amount of claims paid beyond the limitations established in these 21 LCDs.

<b>Local Coverage Requirement</b>	<b>Medicare Payment*</b>	<b>Number of Claims</b>	<b>Number of Providers*</b>
Claims for Lucentis injections more frequently than contractor limits permitted in 2012	\$4,123,516	2,019	271
Claims for tests to diagnose wet AMD more frequently than contractor limits permitted in 2012	\$3,822,131	23,564	1,166
<b>Total</b>	<b>\$7,945,647</b>	<b>25,583</b>	<b>1,354</b>

Source: OIG analysis of 2012 NCH file.

\*Column does not sum to total because some providers potentially inappropriate claims across multiple local coverage requirements.

Three of the twenty-one LCDs used the FDA-approved dosing guidelines to establish every 28 days per eye as the highest frequency at which providers can bill for Lucentis injections to treat wet AMD. However, Medicare paid providers in areas covered by these LCDs approximately \$4.1 million for 2,019 Lucentis injections that were billed for as having been performed sooner than 28 days from a prior Lucentis injection on the same eye. Medicare paid a combined total of \$1 million to six providers for Lucentis injections exceeding this LCD limit. This includes one provider whom Medicare paid \$253,093 for 127 Lucentis injections that were billed in excess of this limit in 2012. Additionally, Medicare paid a total of \$267,834 to six individual providers—who together operated a single surgical group—for Lucentis injections that exceeded this limit. Medicare paid each of these providers between \$20,000 and \$105,000 for such Lucentis injections.

The remaining 18 of the 21 LCDs established limits on the frequency of billing for tests to diagnose wet AMD. Overall, Medicare paid approximately \$3.8 million for 23,564 claims beyond the limitations established by these LCDs. These 18 LCDs established 9 different limitations beyond which the claims processing contractors determined that Medicare should not cover diagnostic tests without additional supporting documentation.<sup>26</sup> For example, some LCDs limit the number of fluorescein angiographies in a calendar year to four per beneficiary diagnosed with wet AMD. However, Medicare paid \$1.4 million to 1 provider for more than 4 fluorescein angiographies for each of 516 such

<sup>26</sup> For these nine different limitations, see “Specific Limitation” column in the table in Appendix B. Depending on the procedure type and the LCD, these limitations range from 2 procedures allowed per eye annually to 12 procedures per eye annually.

beneficiaries in 2012, the highest dollar amount of potentially inappropriate claims paid to any provider. On average, this provider billed for 14 fluorescein angiographies for each of its beneficiaries diagnosed with wet AMD in 2012. However, the majority of providers (1,034 of 1,166) submitting at least one potentially inappropriate claim to diagnose wet AMD did so for 20 or fewer total claims in 2012.

***Two of eleven contractors paid a disproportionate amount of potentially inappropriate Medicare payments***

Overall, Medicare paid a total of \$22.3 million for 94,420 ophthalmology claims that were potentially inappropriate according to national and local coverage requirements. Two Medicare contractors paid \$9 million for 27,851 of these ophthalmology claims. This amounts to 40 percent of all potentially inappropriate payments for ophthalmology claims. However, these contractors paid only about a quarter of all payments for ophthalmology claims in 2012. See Table 4 for the dollar amount of ophthalmology claims that were potentially paid inappropriately and the total dollar amount of ophthalmology claims paid by each contractor.

<b>Contractor</b>	<b>Potentially Inappropriate Medicare Payments</b>	<b>Percentage of Potentially Inappropriate Medicare Payments</b>	<b>Overall Medicare Payments</b>	<b>Percentage of Overall Medicare Payments</b>
Wisconsin Physicians Services	\$5.7 million	26%	\$1.3 billion	16%
First Coast Service Options	\$3.3 million	15%	\$0.8 billion	10%
Palmetto GBA	\$3.1 million	14%	\$1.5 billion	19%
Cahaba GBA	\$2.3 million	11%	\$0.6 billion	7%
Novitas Solutions	\$2.2 million	10%	\$1.2 billion	15%
National Government Services	\$1.4 million	6%	\$0.8 billion	9%
Trailblazer Health Enterprises	\$1.4 million	6%	\$0.6 billion	8%
CGS Administrators	\$1.2 million	5%	\$0.3 billion	4%
Noridian Administrative Services	\$1.0 million	5%	\$0.6 billion	7%
NHIC Corporation	\$0.5 million	2%	\$0.3 billion	4%
Pinnacle Solutions	\$0.2 million	1%	\$0.1 billion	1%
<b>Total*</b>	<b>\$22.3 million</b>	<b>100%</b>	<b>\$8.2 billion</b>	<b>100%</b>

Source: OIG analysis of 2012 NCH file.

\*Columns may not sum to total due to rounding.

The two contractors that paid the highest dollar amount for potentially inappropriate ophthalmology claims each had a strong association with a different local coverage requirement. For example, two-thirds (\$2.2 million of \$3.3 million) of the dollars that First Coast Service Options paid for potentially inappropriate ophthalmology claims were for fluorescein angiographies billed for more than 4 times per beneficiary in 2012. Also, approximately 55 percent (\$3.2 million of \$5.7 million) of the dollars that Wisconsin Physicians Services paid for potentially

inappropriate ophthalmology claims were for Lucentis injections billed for more frequently than 28 days on each eye. Therefore, these two contractors may not have appropriately enforced their own requirements to prevent these payments.

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## CONCLUSION AND RECOMMENDATIONS

Medicare paid approximately \$8.2 billion in 2012 to screen for, diagnose, evaluate, or treat cataracts, wet age-related macular degeneration (wet AMD), and glaucoma. Medicare uses a combination of national and local coverage requirements to determine whether it will cover services for these conditions. However, recent investigations have found that some ophthalmology services for these conditions are vulnerable to fraud, waste, and/or abuse.

Medicare paid approximately \$22 million for 94,420 ophthalmology claims in 2012 that were potentially inappropriate according to national and local coverage requirements. However, we did not review the medical records for any claims to determine if exceptions to the requirements were documented and appropriate. Additionally, two of eleven Medicare contractors paid a disproportionate amount of the potentially inappropriate Medicare payments. Our results demonstrate vulnerabilities in Medicare's oversight and enforcement of its national and local coverage requirements.

Therefore, we recommend that CMS:

### **Implement additional claims processing edits or improve existing edits to ensure claims are paid appropriately**

CMS should ensure that it has claims processing edits to appropriately enforce national requirements. Specifically, these edits should prevent payment for cataract surgeries on eyes of beneficiaries that have already had their natural lens removed. They also should prevent payment for ocular photodynamic therapy claims in which both steps of treatment were not billed as performed on the same day. Additionally, these edits should identify certain claims and flag them for further review. This includes claims for (1) additional cataract diagnostic tests for beneficiaries whose only diagnosis was cataracts and who had already had cataract diagnostic tests in the calendar year and (2) claims for glaucoma screening tests for beneficiaries that are submitted more than once within a 12-month period.

Further, CMS should instruct claims processing contractors to implement claims processing edits or improve existing edits to appropriately enforce LCDs. These edits should identify certain claims and flag them for further review. This includes claims for (1) Lucentis injections that are billed sooner than 28 days after a prior injection on the same eye and (2) claims for tests to diagnose wet AMD more frequently than contractor limits permit.

**Determine the appropriateness of ophthalmology claims identified in this report and take appropriate action**

In a separate memorandum, we will refer to CMS for appropriate action the claims that we identified as potentially inappropriate. CMS and/or its contractors should assess these claims and if warranted, review medical records. After this assessment, CMS should determine and take an appropriate course of action. Appropriate actions could include, but are not limited to: (1) recoupment of any inappropriate payments; (2) provider education on how to properly bill for ophthalmology services; or (3) no action, if billing is determined to be appropriate.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of our recommendations. CMS noted that it is pursuing a comprehensive strategy to combat fraud, waste, and abuse in Medicare. This includes educating providers on appropriate billing for services and improving its centralized portal that provides contractors and law enforcement with access to Medicare data and analytic tools.

CMS concurred with our first recommendation and described its efforts to implement additional or improve existing claims processing edits. CMS stated that it implemented Medically Unlikely Edits regarding ophthalmology services in April 2013 and that it will consider developing edits to address the additional potential vulnerabilities identified in this report. CMS also stated that it will work to enhance the current claims processing edits to prevent inappropriate payment for claims. CMS added that it will educate its contractors of the potential vulnerabilities identified in the report and encourage them to flag these claims for medical review.

CMS concurred with our second recommendation and described its plans to determine the potential return on investment from a medical record review of the claims provided. Based on the analysis and contractor resources, CMS will determine an appropriate number of claims to review. Then, it will take action based on the results of that review.

We support CMS's efforts to address the potential vulnerabilities identified in this report. The full text of CMS's comments is provided in Appendix C.

## APPENDIX A

### The Numbers and Dollar Amounts of Claims Paid Beyond Limitations Established in Each LCD, 2012

LCD	State(s)	Medicare Payment*	Number of Providers*	Number of Claims*	LCD Number
1	IA, IL, IN, KS, MI, MN, MO, NE, WI	\$3,157,914	183	1,535	L32013
2	FL	\$2,183,876	56	9,828	L29177
3	DC, DE, MD, NJ, PA	\$877,662	117	5,016	L27497
4	AL, GA, TN	\$868,065	74	437	L30555
5	KY, OH	\$341,367	122	2,003	L31882
6	CT, NY	\$250,171	173	3,388	L25466
7	KY, OH	\$126,421	290	2,297	L31842
8	AR, CO, LA, MS, NM, OK, TX	\$97,537	16	47	L32642
9	IA, IL, KS, MN, MO, NE, WI	\$38,806	440	948	L29971
10	FL	\$3,579	54	80	L29276
11	PR, VI	\$203	1	2	L29429
12	FL	\$46	2	2	L28982
13	AS, CA, GU, HI, MP, NV	0	0	0	L27584
14	CT, NY	0	0	0	L28488
15	DC, DE, MD, NJ, PA	0	0	0	L27479
16	FL	0	0	0	L28843
17	PR, VI	0	0	0	L29473
18	KY, OH	0	0	0	L31897
19	NC, SC, VA, WV	0	0	0	L31557
20	PR, VI	0	0	0	L28876
21	PR, VI	0	0	0	L29105
<b>Total</b>		<b>\$7,945,647</b>	<b>1,354</b>	<b>25,583</b>	

Source: OIG analysis of 2012 NCH file and LCDs in Medicare Coverage Database.

\*Column does not sum to total because some providers had potentially inappropriate claims according to multiple LCDs.

## APPENDIX B

### The Number and Dollar Amount of Claims Paid Beyond Each of the Limitations Established in LCDs, 2012

Type of Limitation	Specific Limitation	Jurisdiction Having Limitation	Medicare Payment*	Number of Providers *	Number of Claims*
Limitation to prevent payment for claims indicating that providers billed for beneficiaries to have tests to diagnose wet AMD more frequently than contractor-established limits	HCPCS code 92235 is not allowed more than 4 times per eye per year for patients diagnosed with wet AMD. <sup>27</sup>	J09, J12	\$2,991,705	142	14,561
	HCPCS code 92250 is not allowed more than 2 times per eye per year.	J13, J15	\$376,139	463	5,667
	HCPCS codes 92235 and 92240 are not allowed within 30 days of one another on the same eye, unless the patient has a second diagnosis in addition to wet AMD. However, the second diagnosis cannot be diabetic retinopathy.	J01, J11, J15	\$341,367	122	2,003
	HCPCS codes 92235 and 92240 are not allowed within 30 days of one another on the same eye, unless they are provided on the same day.	J12	\$70,333	48	286
	HCPCS codes 92133 and 92134 are not allowed within 28 days of one another on the same eye for patients diagnosed with retinal diseases (including wet AMD).	J05, J06	\$38,806	440	948
	HCPCS codes 92133 and 92134 are not allowed on the same day for the same eye.	J09	\$3,625	56	82
	HCPCS codes 92225 and 92226 are not allowed more than 12 times per eye per year for patients diagnosed with wet AMD.	J13, J15	\$453	2	18
	HCPCS codes 92235 and 92240 are not allowed more than 9 times per eye per year.	J01, J11, J15	-	-	-
	HCPCS code 92134 is not allowed more than 1 time per eye per month.	J13, J15	-	-	-
Limitation to prevent payment for claims indicating that Lucentis injections were provided more often than contractor-established limits	HCPCS code J2778 is not allowed more often than every 28 days per eye diagnosed with wet AMD.	J04, J05, J06, J07, J08, J10	\$4,123,516	271	2,019
<b>Total</b>			<b>\$7,945,647</b>	<b>1,354</b>	<b>25,583</b>

Source: OIG analysis of 2012 NCH file and LCDs in Medicare Coverage Database.

\*Column does not sum to total because some providers had potentially inappropriate claims according to multiple LCDs.

<sup>27</sup> Medicare Part B services are classified and paid using Healthcare Common Procedure Coding System (HCPCS) codes.

## APPENDIX C

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** NOV - 7 2014

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Marilyn Tavenner /S/  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Medicare Paid \$22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims," (OEI-04-12-00281)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on this draft report. CMS is committed to eliminating fraud, waste, and abuse in Medicare.

To combat fraud, waste, and abuse in Medicare, CMS is pursuing a comprehensive strategy comprised of several initiatives. Specific to ophthalmology claims, CMS has released educational materials on ophthalmological benefits to educate physicians and other providers on the coverage and billing requirements for ophthalmological services. The published materials specify that glaucoma screening is covered annually and that providers may only bill for cataract removal once per eye.

CMS is continually improving and updating its fraud, waste, and abuse prevention efforts. CMS has used authority granted by the Affordable Care Act to establish temporary moratoria on the enrollment of high-risk providers in fraud "hot spots." We have also continued making improvements and changes to One Program Integrity (One PI), CMS' centralized portal that provides CMS contractors and law enforcement with access to Medicare data and analytic tools to review the data. In addition, CMS has implemented the Fraud Prevention System (FPS), which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing behavior.

The OIG's recommendations and CMS' responses to those recommendations are discussed below.

**OIG Recommendation**

Implement additional claims processing edits or improve existing edits to ensure claims are paid appropriately

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## APPENDIX C

### Agency Comments (Continued)

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**CMS Response**

CMS concurs with this recommendation. In April 2013, CMS implemented Medically Unlikely Edits regarding ophthalmological services. CMS will consider developing claims processing edits to address the additional potential vulnerabilities identified in this report.

In addition, CMS will continue to educate our contractors of the potential vulnerabilities regarding additional cataract diagnostic tests for beneficiaries whose only diagnosis was cataracts and who had already had cataract diagnostic tests in the calendar year and claims for glaucoma screening tests for beneficiaries that are submitted more than once within a 12-month period and encourage them to flag these claims for medical review.

CMS will work to enhance the current claims processing edits to prevent inappropriate payments for ophthalmology claims.

**OIG Recommendation**

Determine the appropriateness of ophthalmology claims identified in this report and take appropriate action

**CMS Response**

CMS concurs with this recommendation. CMS requests that OIG furnish the necessary data (e.g. Medicare contractor number, provider number, claims information including the paid data, claim number, Health Insurance Claim Number, overpaid amount, etc.) to follow-up on the claims. In addition, CMS requests that current Medicare contractor-specific data be sent through a secure portal to better facilitate the transfer of information to the appropriate contractor.

Upon receipt of the files from OIG, CMS will conduct an analysis to determine the potential return on investment from a medical review of the claims provided. Based on the analysis and contractor resources, CMS will determine an appropriate number of claims to review.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

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## ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Stewart, Deputy Regional Inspector General.

Evan Godfrey served as the lead analyst for this study. Central office staff who provided support include: Clarence Arnold, Scott Horning, Scott Manley, Christine Moritz, and Dave Tawes.

# Office of Inspector General

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