OIG: "Medicare Paid $22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims"

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Late last year, the Office of Inspector General (OIG) published a study on ophthalmology billing. Based on 2012 claims data, the report focused on three conditions—wet age-related macular degeneration (AMD; $2.2 billion in 2012), cataract ($3.5 billion), and glaucoma ($1.3 billion).

Some context. The report found payments totaling $22 million that perhaps shouldn't have been paid. (That amount is much less than 1 percent of the total amount that Medicare paid for the three conditions in the study.) And when those potentially improper payments are broken down by provider, the study found that 74 percent of providers received no such payments and 16 percent received less than $1,000.

Why were claims deemed *potentially* inappropriate? In some cases, national requirements dictate when a service is covered; in others, the bodies that administer Medicare regionally—the Medicare Administrative Contractors (MACs)—can each establish their own local requirements. In 2012, $14 million was paid for services that didn't meet national requirements, and $8 million was paid for services that didn't meet local coverage determinations (LCDs). But the study didn't look at medical records to see if practices had documented any valid exceptions to those requirements.

Wet AMD

Payments for wet AMD–related services were classed as potentially inappropriate when claims for the following codes didn't meet LCD requirements.

- CPT code 92235 *Fluorescein angiography*—some LCDs set an annual limit for this service.
- CPT code 92250 *Fundus photography*—under some MAC LCDs, this is not allowed more than two times per eye per year.
- CPT codes 92235 *Fluorescein angiography* and 92240 *Indocyanine-green angiography*—some LCDs state that these are not allowed within 30 days of one another on the same eye, unless performed on the same day or unless the patient has a second diagnosis in addition to wet AMD. Furthermore, the second diagnosis cannot be diabetic retinopathy. Combined frequency edits are not to exceed nine times per eye per year.
- CPT codes 92133 *Posterior segment imaging* (glaucoma) and 92134 *Posterior segment imaging* (retina)—not allowed on the same day for the same eye by any payer.
- CPT code 92134 *Posterior segment imaging* (retina)—not allowed more than once a month.
- CPT codes 92225 *Extended ophthalmoscopy* and 92226 *Subsequent ophthalmoscopy*—under some LCDs, the combined frequency edits for these two codes are 12 times per eye per year.
- HCPCS code J2778 *Lucentis* is not allowed more often than every 28 days, per the label instructions.

Cataract

Two national coverage requirements for cataract weren't always met.

- Medicare will not routinely cover more than one comprehensive eye examination and scan for patients whose only diagnosis is cataract. However, in 2012, such claims were paid more than 52,000 times.
- Medicare will not cover cataract surgery for an eye that has already undergone that procedure. In 2012, such claims were paid 10,560 times.

Glaucoma

A national requirement states that Medicare covers glaucoma screenings once every 12 months for patients at high risk for glaucoma. But the report noted that 5,055 payments were made for screening tests performed less than 12 months after the previous one.

What Next?

CMS may instruct MACs to take further action to recoup any inappropriate payments from practices.

For links to MAC websites and their LCDs, go to www.aao.org/coding and select "Coding Updates and Resources."

Read the complete OIG report at http://oig.hhs.gov/oei/reports/oei-04-12-00281.asp. ■