Department of Health and Human Services
Office of Inspector General
Office of Audit Services

December 2025 | A-05-24-00009

Medicare Improperly Paid Selected Optometrists for Services Provided to Enrollees at Nursing Facilities

REPORT HIGHLIGHTS

December 2025 | A-05-24-00009

Medicare Improperly Paid Selected Optometrists for Services Provided to Enrollees at Nursing Facilities

Why OIG Did This Audit

- OIG data analysis identified Medicare Part B payments made to optometrists for high-level evaluation and management (E/M) services not usually billed by optometrists.
- For 2021 through 2023 (audit period), Medicare paid $4.7 million to 200 optometrists for E/M services for moderate to highly complex subsequent nursing facility care. The top 15 optometrists accounted for 72 percent of those payments.
- This audit examined whether the 15 optometrists complied with Medicare requirements when billing for services at nursing facilities.

What OIG Found

- CMS reimbursed selected optometrists for Part B services that were not billed in accordance with Medicare requirements. All 225 of the enrollees we sampled had associated claim lines of service that did not meet Medicare documentation or coding requirements. All 399 lines of services billed as high-level E/M codes for the sampled enrollees did not meet Medicare requirements.
- We estimated that Medicare overpaid the selected optometrists at least $3 million for E/M services during our audit period.
- CMS did not perform any claim reviews of optometrists' billing and did not have system edits in place to prevent the billing of these codes.

What OIG Recommends

We made three recommendations to CMS, including that it recover the portion of the $3 million in estimated overpayments that are within the 4-year reopening period, increase claim reviews, and develop system edits to prevent the incorrect billing of services. The full recommendations are in the report.

CMS concurred with two recommendations. CMS did not fully concur with the third recommendation to increase claim reviews and develop system edits.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

Medicare covers many medical services provided to its enrollees, including those residing in nursing facilities. Nursing facilities are required to provide services necessary to ensure their residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. Sometimes, nursing facilities do not have the staff to meet their residents' needs and therefore arrange for outside resources to furnish services. For example, optometrists typically visit nursing facilities to provide services because transportation to and from an eye appointment might be difficult for some residents. These services typically include eye exams for residents with diabetes and those at high risk for glaucoma, and diagnostic tests and treatment for residents with age-related macular degeneration.[1]

Using data analysis, we identified Medicare Part B payments made to 200 optometrists nationwide for subsequent nursing facility care services not usually billed by optometrists. Of the 200 optometrists, 15 billed 72 percent of these types of services. We conducted this audit to determine whether these services met Medicare requirements.

OBJECTIVE

Our objective was to determine whether selected optometrists billed Part B services for enrollees residing in nursing facilities in accordance with Medicare requirements.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Medicare Part B provides supplementary insurance for medical and other health services, such as evaluation and management (E/M) services.[2]

[1] Glaucoma is an eye disease that gradually deteriorates vision by causing damage to the optic nerve. Age-related macular degeneration is an eye disease that affects central vision, specifically the central part of the retina. It is more likely to occur as people get older.

[2] Physicians and nonphysician practitioners perform E/M services to assess and manage an enrollee's health.

Medicare Requirements for Evaluation and Management Services

E/M services are cognitive services in which physicians or other qualified health care professionals (providers) diagnose and treat illness or injury.[3] Section 1862(a)(1)(A) of the Act states that Medicare only covers services that are considered reasonable and necessary for the diagnosis or treatment of illness or to improve functioning of a malformed body member.

CMS adopted the Current Procedural Terminology (CPT®)[4, 5] coding system as part of the Healthcare Common Procedure Coding System (HCPCS) and mandated that providers use these coding systems to bill all physician services.[6, 7] Providers are responsible for billing the appropriate codes to Medicare. It is not medically necessary or appropriate to bill a higher level code when a lower level code is warranted, and the documentation should support the level of service provided.[8] Section 1833(e) of the Act prohibits payment for a claim that is missing necessary information. When billing for covered services, medical providers must also comply with Medicare billing requirements.

Evaluation and Management Services for Subsequent Nursing Facility Care

The codes providers use to bill E/M services are organized into various categories and levels. The codes distinguish between new and established patients, and, in general, the more complex the visit, the higher the level of code a provider may bill within the appropriate category. To determine the appropriate code, providers must consider key components such as

[3] Cognitive services involve the application, based on relevant knowledge and experience, of such skills as data gathering and analysis, planning, management, decision-making, and judgment relating to the prevention, diagnosis, and treatment of health problems, and communication of such information to the patient.

[4] *CPT copyright 2020, 2021, and 2022 American Medical Association. All rights reserved.*

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

[5] **U.S. Government End Users**. CPT is commercial technical data, which was developed exclusively at private expense by the American Medical Association (AMA), 330 North Wabash Avenue, Chicago, Illinois 60611. Use of CPT in connection with this product shall not be construed to grant the Federal Government a direct license to use CPT based on FAR 52.227-14 (Data Rights - General) and DFARS 252.227-7015 (Technical Data - Commercial Items).

[6] HCPCS is a standardized coding system CMS uses to process claims for insurance payments.

[7] 45 CFR §§ 162.1000, 162.1002.

[8] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1.

the description of the patient, history and examination, and level of medical decision-making, as well as the amount of time spent with the patient.[9, 10]

According to the American Medical Association (AMA) *CPT Professional Code Book*, CPT codes 99307 through 99310 are for nursing facility care subsequent to initial admission for patients residing in a nursing facility (referred to as "E/M services" throughout this report).[11] These codes are billed daily for nursing facility care, for the evaluation and management of a patient. The codes refer to different levels of complexity (low-level to high) and requires that two of three components be met to support the services billed to Medicare. For calendar years 2021 and 2022 (the first 2 years of our January 1, 2021, through December 31, 2023, audit period), CPT codes 99307 or 99308 indicate low-level complexity services for a patient who is stable or has only a minor complication, and that include a problem-focused or expanded problem-focused history and exam, involving straightforward or low-level medical decision-making.[12] CPT codes 99309 or 99310 indicate high-complexity services for a patient with a significant complication or a new problem, or an unstable and significant new problem requiring immediate physician attention, and that include a detailed or comprehensive history and exam and moderate- to high-complexity medical decision-making. There is also a typical amount of time (in minutes) associated with each CPT code. Table 1 details AMA's guidance for these codes for 2021 and 2022.

Table 1: AMA Guidance of Complexity Levels for Subsequent Nursing Facility Care for 2021 and 2022

Complexity Level	CPT Code	Components Required: 2 of 3			Time (minutes)
		Description of Patient	History & Exam	Medical Decision Making	
Low	99307	Stable/Recovering or Improving	Problem Focused	Straightforward	10
↓	99308	Responding Inadequately to Therapy or Minor Complication	Expanded Problem Focused	Low	15
↓	99309	Significant Complication or Significant New Problem	Detailed	Moderate	25
High	99310	Unstable or Significant New Problem Requiring Immediate Physician Attention	Comprehensive	High	35

[9] CMS, *1997 Documentation Guidelines For Evaluation and Management Services*.

[10] American Medical Association, *Evaluation and Management (E/M) Services Guidelines*.

[11] *CPT copyright 2020, 2021, and 2022 American Medical Association. All rights reserved.*

[12] This was the most recent data available when we started our audit.

AMA's guidance for 2023 included multiple changes to the CPT code components in Table 1, including a new multiple morbidities requirement and changes in the history and exam requirement and the required time spent with the patient. The guidance for 2023 noted that all levels of these codes should be used only when the patient has multiple morbidities requiring intensive management. This means that it is only appropriate to use these codes if patients have conditions, syndromes, or functional impairments that are likely to require frequent medication or treatment changes or re-evaluations, and the patients are at significant risk of worsening medical status and admission or readmission to a hospital. The 2023 guidance also clarified that codes 99307 through 99310 require a medically appropriate history or examination or both. In addition, the guidance increased the amount of time the provider is expected to spend with a patient. Specifically, the time requirement must meet or exceed 10 minutes for code 99307, 15 minutes for code 99308, 30 minutes for code 99309, and 45 minutes for code 99310.

CMS and Medicare Administrative Contractor Oversight

CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Medicare Part B claims. CMS requires MACs to conduct provider oversight in their jurisdictions. This includes educating providers about Medicare coverage and billing requirements through training and published articles. The MACs are also required to implement claim processing edits and review selected claims to ensure compliance with Medicare requirements.[13, 14] Claim processing includes receiving claims from providers, performing claim edits, and adjudicating claims. According to CMS officials, they have no edits in place to limit which CPT codes are billed by optometrists, but two MACs have implemented their own edits.[15] As stated in the Medicare Program Integrity Manual, each MAC should coordinate their oversight efforts with CMS, the other MACs, and other CMS contractors.[16]

[13] CMS, Medicare Program Integrity Manual, Pub. No. 100-08, ch. 1, § 1.3.1.

[14] An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, acts on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

[15] There are 7 MACs that were awarded 12 geographic jurisdictions to process Part B medical claims.

[16] CMS, Medicare Program Integrity Manual, Pub. No. 100-08, ch. 1, § 1.3.10 outlines the coordination among contractors. Other CMS contractors include Recovery Audit Contractors, Supplemental Medical Review Contractors, and Unified Program Integrity Contractors, all of whom support CMS's audit, oversight, antifraud, waste, and abuse efforts.

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part B payments made to selected optometrists for services performed at nursing facilities during our audit period. [17] We focused on CPT codes 99309 and 99310, which are E/M services for moderate to high complexity level subsequent nursing facility care.

During the audit period, Medicare paid $4.7 million to 200 optometrists for services billed using CPT codes 99309 or 99310. Of the 200 optometrists, we selected the 15 optometrists who billed the most claims at nursing facilities for these CPT codes. These 15 optometrists accounted for 72 percent of Medicare payments for CPT codes 99309 and 99310 during our audit period. We selected a stratified random sample of 15 enrollees from each of the 15 optometrists, for a total of 225 sampled enrollees. For those 225 sampled enrollees, we reviewed all the paid claims billed by the selected optometrists that included CPT codes 99309 or 99310. We reviewed all lines of service on each claim, which sometimes included imaging services for photographs or drawings of the eye in addition to the E/M code. Since some optometrists visited sampled enrollees multiple times during the audit period, the 225 sampled enrollees were associated with a total of 414 lines of service billed (399 E/M services and 15 imaging services) totaling $35,729 in Medicare payments.

We requested and reviewed the sampled enrollees' medical records to determine whether the records supported the billed codes. We shared some medical records with CMS to confirm it agreed with our determinations of services that did not comply with E/M billing requirements. CMS reviewed those records and confirmed our determinations. Based on our sample results, we estimated the total overpayment amount for lines of service provided during our audit period that were not in compliance with Medicare requirements.

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 A contains the details of our audit scope and methodology. Appendix B contains the Medicare billing and contractor requirements, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

Selected optometrists billed Medicare for Part B services provided to enrollees residing in nursing facilities that were not in accordance with Medicare requirements. All 225 sampled

[17] Provider specialty code 41 is used for optometrists. Place of service code 32 is used for nursing facilities.

enrollees had associated claim lines of service that did not meet Medicare documentation or coding requirements, resulting in overpayments of $35,170.

The overpayments occurred because CMS's oversight was not sufficient to ensure that optometrists complied with Medicare requirements. CMS stated that it has not instructed contractors to perform any pre- or post-payment reviews of optometrists billing these codes. Further, CMS did not have edits in place to prevent optometrists from billing these high-level E/M codes for subsequent nursing facility services. Also, CMS did not provide provider-specific education or training on billing for optometry services provided to enrollees residing in nursing facilities.

On the basis of our sample results, we estimated that CMS reimbursed selected optometrists at least $3 million for E/M services that were not billed in accordance with Medicare requirements.[18]

SELECTED OPTOMETRISTS DID NOT MEET MEDICARE REQUIREMENTS FOR EVALUATION AND MANAGEMENT SERVICES BILLED

All 225 sampled enrollees had associated services that did not meet Medicare requirements. Of the associated 414 lines of services we reviewed, all 399 E/M lines of service (i.e., billed as CPT 99309 or 99310) did not meet Medicare requirements. For 395 lines of service, totaling $34,841, the medical records did not support the billed E/M codes. For the remaining four lines of service, totaling $329, the one associated optometrist could not locate any medical records related to the billed E/M codes.

Medical Records Did Not Support Billed Evaluation and Management Codes

Section 1862(a)(1)(A) of the Act states that Medicare only covers services that are considered reasonable and necessary for the diagnosis or treatment of illness or to improve functioning of a malformed body member. Providers are responsible for billing the appropriate codes to Medicare.

E/M codes are organized into various categories and levels that represent the variations in skill, knowledge, and work required for different patient encounters. In general, the more complex the encounter, the higher the level of code providers may bill. Providers must choose the code that best represents the complexity of the relevant history, physical examination, and medical decision-making.

As stated in the AMA's *CPT Professional* AMA *Code Book*, CPT codes 99309 and 99310 indicate increasingly complex services. These codes are billed for subsequent nursing facility care for patients with a significant problem or complication, or who are unstable or require immediate provider attention. The 2023 guidance further explains that these codes are billed when the

[18] The total estimated overpayment was $3,059,204.

patient has multiple morbidities and are at risk of worsening medical status and (re)admission to a hospital.

For 395 lines of service associated with all 225 sampled enrollees, the medical record documentation did not support the billing of CPT code 99309 or 99310, resulting in inappropriate payments of $34,841. Specifically, the medical records did not support the requirements for billing subsequent nursing facility care for the evaluation and management of a patient.

Most medical records indicated a chief complaint of dry or itchy eyes, often treated with eye drops and a recommendation to follow up in a few months. Some medical records mentioned blurry vision and the optometrist following up on cataract growth. However, there was no mention of any enrollees in unstable condition or requiring immediate provider attention, only that the enrollee required an eye exam. Some documentation indicated that the nursing facility requested an optometrist visit weeks or even months before the E/M date of service, further indicating that these were routine visits and not an optometrist rushing to help an unstable enrollee with a new problem that required immediate provider attention. Also, the medical records did not state the total number of minutes the optometrists spent with the patients, as described in the time limitations assigned to each CPT code definition.

According to CMS officials, CMS has no edits in place to limit which CPT codes are billed by optometrists at nursing facilities. However, two MACs have implemented their own edits for codes that can be billed by optometrists, including the E/M codes we reviewed.

No Medical Records Provided To Support Billed Evaluation and Management Codes

Section 1833(e) of the Act states that no payment shall be made unless providers furnish information necessary to determine the amount due to the provider. One optometrist could not provide any medical record documentation to support four lines of service billed on behalf of four sampled enrollees. The optometrist was reimbursed a total of $329 for these lines of service. The optometrist's office stated that it did not retain medical records, and the associated nursing facility could not produce any documentation for the optometrist's visits.

ESTIMATE OF OVERPAYMENT

Based on our sample results, we estimated that Medicare overpaid at least $3 million to the 15 selected optometrists for E/M services that were not billed in accordance with Medicare requirements. As of the publication of this report, this amount includes claims outside of the Medicare 4-year claim reopening period.[19]

[19] 42 CFR § 405.980(b)(2) states contractors can reopen a claim to change determination of payment for good cause within 4 years of its payment date.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- collaborate with CMS contractors to review all claims submitted by the 15 selected optometrists to determine compliance with Medicare requirements and recover the portion of the $3,059,204 in estimated overpayments made to those optometrists during our audit period that are within the 4-year reopening period;

- instruct the CMS contractors to notify, as the contractors deem appropriate, providers in our sample that received an overpayment(s) to consider conducting one or more internal audits or investigations based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified funds to the Medicare program; and

- instruct CMS contractors to:

    - provide training and guidance that are specific to Medicare requirements for billing optometrist services provided in nursing facilities,

    - increase claim reviews of optometrists' E/M services, and

    - develop system edits to prevent the incorrect billing of E/M services.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first two recommendations and described corrective actions it planned to take to address the recommendations. However, CMS did not fully concur with the third recommendation. After reviewing CMS's comments, we maintain that our recommendations are valid.

CMS's comments are included in their entirety as Appendix E.

CMS COMMENTS

CMS concurred with the first recommendation that it collaborate with CMS contractors to review all claims submitted by the 15 selected optometrists to determine compliance with Medicare requirements and recover the portion of the $3,059,204 in estimated overpayments made to those optometrists during our audit period that are within the 4-year reopening period. CMS stated that it concurs with this recommendation; however, due to resource limitations, CMS will review a sample of these claims and initiate recovery according to CMS policies and procedures.

CMS concurred with the second recommendation and stated that CMS will share this audit with CMS contractors to use in their risk analysis and work planning.

CMS did not fully concur with our third recommendation. CMS concurred with the portion of our recommendation to provide education on billing requirements for optometrists providing services in nursing facilities. Because a limited number of optometrists accounted for the majority of improper payments, CMS non-concurred with increasing claim reviews and developing system edits. While CMS will share this report with contractors as indicated in the response to our second recommendation, CMS stated that contractors are required to use their limited resources on areas with the biggest impact on the Medicare trust fund.

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge the actions that CMS plans to take to address the first and second recommendation.

Regarding our third recommendation, we maintain that our recommendation is valid. The selected optometrists represented 72 percent of the Medicare payments for CPT codes 99309 and 99310 during our audit period. We found improper payments associated with all 225 sampled enrollees in our audit, resulting in an estimated overpayment amount of at least $3 million. CMS agreed with our determination that the supporting documentation for the payments did not comply with E/M billing requirements.

To strengthen program integrity and reduce financial risk to Medicare, we continue to recommend that CMS review claims and refine its system edits to prevent improper payments to optometrists providing services at nursing facilities.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

During the audit period, Medicare paid $4.7 million to 200 optometrists for services billed using CPT codes 99309 or 99310.[20] Of the 200 optometrists, we selected the 15 optometrists who billed the most claims at nursing facilities for these CPT codes. These 15 optometrists accounted for 72 percent of Medicare payments for CPT codes 99309 and 99310 during our audit period. We selected a stratified random sample of 15 enrollees from each of the 15 optometrists, for a total of 225 sampled enrollees. For those 225 sampled enrollees, we reviewed all the paid claims billed by the selected optometrists that included CPT codes 99309 or 99310. We reviewed all lines of service on each claim, which sometimes included imaging services for photographs or drawings of the eye in addition to the E/M code. Since some optometrists visited sampled enrollees multiple times during the audit period, the 225 sampled enrollees were associated with a total of 414 lines of service billed (399 E/M services and 15 imaging services), totaling $35,729 in Medicare payments.

We did not review the Medicare program's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective. This included reviewing CMS's management oversight structure and its established policies, procedures, and processes for controlling and assessing risks related to providers' compliance with Medicare requirements for E/M services.

We conducted our audit from January 2024 through September 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained paid Medicare Part B claim data from CMS's Integrated Data Repository;
- analyzed claim data to identify:
  - unusual or duplicative billing,
  - coding trends by optometrist,
  - frequency with which optometrists billed E/M codes, and
  - number of billed services per enrollee;
- interviewed CMS officials to gain an understanding of the requirements and oversight of optometrists billing Part B services at nursing facilities;

[20] *CPT copyright 2020, 2021, and 2022 American Medical Association. All rights reserved.*

- researched key components and requirements for the billed CPT codes;

- identified the top 15 optometrists who were paid for at least 1,000 lines of CPT 99309 or 99310 during the audit period;

- selected a stratified random sample of 15 enrollees from each of the 15 optometrists for a total of 225 sampled enrollees for review (Appendix C);

- contacted the 15 optometrists to request supporting documentation for the 225 sampled enrollees and the 414 lines of service associated with those 225 sampled enrollees, and reviewed the medical records to determine whether they supported the CPT code billed;

- estimated the total amount of overpayments for lines of service in our sampling frame that did not meet applicable Medicare billing requirements (Appendix D); and

- discussed our findings with CMS 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: MEDICARE BILLING AND CONTRACTOR REQUIREMENTS

MEDICARE BILLING REQUIREMENTS AND GUIDANCE

Section 1833(e) of the Act prohibits Medicare payment for a claim that is missing necessary information. Specifically:

> No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

Section 1862(a)(1)(A) of the Act states that Medicare will cover only services that are reasonable and necessary for the diagnosis or treatment of illness or to improve functioning of a malformed body member.

CMS Publication 100-04, *Medicare Claims Processing Manual*, chapter 12: 30.6.1, section B, explains that medical necessity of a service is a criterion for payment in addition to the individual requirements of an E/M visit code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

MEDICARE CONTRACTOR REQUIREMENTS

CMS Publication 100-08, *Medicare Program Integrity Manual*, ch. 1, § 1.3.1, states that CMS contracts with MACs to process and pay Medicare claims. MACs are responsible for conducting medical reviews and developing provider education on identified areas of vulnerability.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 21,749 provider-enrollees[21] on whose behalf the top 15 providers[22] submitted 39,409 claims, for which they were reimbursed $3,511,659 by Medicare. These claims included CPT codes 99309 or 99310 with dates of service from January 1, 2021, through December 31, 2023.[23]

SAMPLE UNIT

The sample unit was a Medicare provider-enrollee.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing 15 strata based on the top 15 optometrists. We selected 225 provider-enrollees for review, as shown in Table 2 on the next page.

[21] A provider-enrollee is all claims in our sampling frame that a provider submitted (and Medicare reimbursed) on behalf of a single enrollee. If more than one provider was reimbursed for claims on behalf of the same enrollee, then that enrollee will appear more than once in the sampling frame.

[22] These are the 15 optometrists that Medicare paid the highest number of claims containing CPT codes 99309 and 99310 provided during our audit period.

[23] *CPT copyright 2020, 2021, and 2022 American Medical Association. All rights reserved.*

Table 2: Frame Description and Sample Size

Strata	Provider	Provider-Enrollees	Sample Size
1	A	2,502	15
2	B	2,314	15
3	C	2,805	15
4	D	1,997	15
5	E	892	15
6	F	1,434	15
7	G	1,743	15
8	H	1,364	15
9	I	1,246	15
10	J	1,221	15
11	K	655	15
12	L	1,083	15
13	M	869	15
14	N	770	15
15	O	854	15
Totals		**21,749**	**225**

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG/Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the sample units in each stratum in ascending order by enrollee health insurance claim number and then consecutively numbered the items in each stratum in the sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments for claims in our sampling frame that did not meet applicable Medicare billing requirements. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval using this software.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 3: Sampling Frame Details

Strata	Provider	Number of Frame Units (Provider-Enrollees)	Dollar Value of Frame	Sample Size	Number of Lines of Service in Sample	Dollar Value of Sample
1	A	2,502	$658,212	15	35	$3,050
2	B	2,314	336,345	15	27	2,184
3	C	2,805	266,614	15	17	1,309
4	D	1,997	271,279	15	24	2,006
5	E	892	294,574	15	48	4,831
6	F	1,434	241,775	15	30	2,396
7	G	1,743	276,850	15	25	2,472
8	H	1,364	220,635	15	25	2,435
9	I	1,246	180,206	15	20	1,869
10	J	1,221	142,224	15	25	1,971
11	K	655	154,948	15	34	2,947
12	L	1,083	153,865	15	25	2,287
13	M	869	99,248	15	23	1,793
14	N	770	113,526	15	36	2,598
15	O	854	101,359	15	20	1,580
	Totals*	**21,749**	**$3,511,659**	**225**	**414**	**$35,729**

*The dollar amounts may not add up exactly due to rounding.

Table 4: Sample Results

Strata	Provider	Number of Incorrectly Billed Sample Items	Number of Lines of Service in Sample	Incorrectly Billed Lines of Service in Sample	Dollar Value of Sample	Net Value of Overpayments in Sample
1	A	15	35	35	$3,050	$3,050
2	B	15	27	27	2,184	2,184
3	C	15	17	17	1,309	1,309
4	D	15	24	23	2,006	1,802
5	E	15	48	48	4,831	4,831
6	F	15	30	30	2,396	2,396
7	G	15	25	25	2,472	2,472
8	H	15	25	25	2,435	2,435
9	I	15	20	20	1,869	1,869
10	J	15	25	25	1,971	1,971
11	K	15	34	34	2,947	2,947
12	L	15	25	22	2,287	2,250
13	M	15	23	23	1,793	1,793
14	N	15	36	27	2,598	2,332
15	O	15	20	18	1,580	1,527
Totals*		**225**	**414**	**399**	**$35,729**	**$35,170**

*The dollar amounts may not add up exactly due to rounding.

Table 5: Estimated Total Amount of Net Overpayments to the 15 Optometrists in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	$3,272,823
Lower limit	3,059,204
Upper limit	3,486,443

APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: October 28, 2025

TO: Carla J. Lewis
Acting Deputy Inspector General for Audit Services

FROM: Mehmet Oz, M.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Improperly Paid Selected Optometrists for Services Provided to Enrollees at Nursing Facilities* (A-05-24-00009)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that providers are billing for services in accordance with Medicare requirements.

When a nursing facility cannot provide a necessary service for a resident, such as an optometric exam, the nursing facility may need outside health care providers to perform these specialized services. These types of covered professional services rendered by optometrists to individual beneficiaries are covered as physicians' services under Medicare Part B. Treating optometrists may bill evaluation and management (E/M) codes, which are paid based on the complexity of medical decision making necessary for the visit, ranging from low to high.

When a Medicare beneficiary who is a nursing home resident receives services from an outside physician, the physician submits claims to Medicare for their professional services directly to the Medicare Administrative Contractors (MACs) who then process and pay the Medicare Part B claims.

CMS has provided guidance to the MACs in the Medicare Claims Processing Manual to assist in ensuring claims are coded and paid for accurately. As OIG notes in its report, two MACs have implemented edits to limit which codes are billed by optometrists. Additionally, while not specific to optometry, CMS has issued guidance to providers and suppliers on billing E/M codes to beneficiaries in a nursing facility.

It is also important to note that MACs are instructed to target their efforts at error prevention on those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. This requires establishing a priority setting process to ensure medical review focuses on areas with the greatest potential for improper payment. As OIG notes within their report, their review covered only 15 selected optometrists who were E/M

billing outliers with potentially improper payments amounting to approximately $35,000 in total. While CMS will share these findings with the contractors for review, they will prioritize services for review in their jurisdictions based on their analysis of risks and trends.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should collaborate with CMS contractors to review all claims submitted by the 15 selected optometrists to determine compliance with Medicare requirements and recover the portion of the $3,059,204 in estimated overpayments made to those optometrists during our audit period that are within the 4-year reopening period.

CMS Response

CMS concurs with this recommendation. Due to resource limitations, CMS will review a sample of these claims and initiate recovery according to CMS policies and procedures.

OIG Recommendation

CMS should instruct the CMS contractors to notify, as the contractors deem appropriate, providers in our sample that received an overpayment(s) to consider conducting one or more internal audits or investigations based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified funds to the Medicare program.

CMS Response

CMS concurs with this response. CMS will share this audit with CMS contractors to use in their risk analysis and work planning.

OIG Recommendation

CMS should instruct CMS contractors to:

- provide training and guidance that are specific to Medicare requirements for billing optometrist services provided in nursing facilities,
- increase claim reviews of optometrists' E/M services, and
- develop system edits to prevent the incorrect billing of E/M services.

CMS Response

CMS concurs to provide education on billing requirements for optometrists providing services in nursing facilities. Given the limited number of optometrists accounting for the majority of improper payments, CMS non-concurs with increasing claim reviews and developing system edits. While CMS will share this report with contractors as indicated in the response to Recommendation 2 above, contractors are required to use their limited resources on areas with the biggest impact on the Medicare trust fund.

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

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov