# Optometry Coding & Billing Alert

## News You Can Use: Documentation Errors Cost Practices $1.3 Billion in 2007

Insufficient documentation may cost optometrists over $17 million

Can't seem to get yourself to document thoroughly? The latest CERT report results might help refocus your attention on proper documentation very quickly.

According to the most recent Comprehensive Error Rate Testing (CERT) results, Medicare requested $9.3 billion in reimbursement back from practices that lacked complete documentation, and your practice may have been one of them.

The new CERT results, which reported data from claims submitted to Medicare between Oct. 1, 2006, and Sept. 30, 2007, were released May 16.

**Upside:** The new report wasn't all bad news, however. Despite an improper-payment tally of $10.2 billion (including both overpayments and nearly $1 billion in underpayments), the error rate dropped to just 3.4 percent, a small fraction of the whopping 14 percent error rate that CMS found in 1996.

CMS counted more than $785 million in errors for practices that were missing documentation, and $1.3 billion in insufficient-documentation errors. This number is alarming, but the figure becomes even worse when you hear just what types of errors CMS discovered.

"The fact that the error rate has dropped is great news," says **Jay Neal,** a consultant in Atlanta. "But an error rate of over $10 billion is still high."

Neurosurgeons, OTs Lead in Errors

Optometrists had only a 2.9 percent error rate in paid claims, leading to $17,105,734 in projected improper payments. Occupational therapists logged an astounding 21.2 percent error rate, and neurosurgeons weren't far behind with an error rate of 15.3 percent.

**Watch for:** If your favorite code is 99211, watch out. A new CMS report reveals that more than 15 percent of claims submitted to Part B for this code last year were missing critical documentation, causing Medicare to request more than $20 million back from providers.

The CERT report found 99211 (Outpatient E/M that may not require a physician) billed inappropriately across the board, both in the "insufficient documentation" and "no documentation" categories.

"Practices may be surprised by this high error rate because many people think it doesn't take comprehensive documentation to report 99211," says **Heather Corcoran** with CGH Billing. "But that's probably the exact reason it's billed in error so often -- practitioners assume because it's a low-level code, they don't have to document very much information, which is wrong."