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Face-to-face denials show problems with signatures, homebound documentation

Claim denials based on face-to-face encounter documentation often are the result of insufficient physician narratives, but errors relating to signatures or dates also are causing agencies to lose reimbursement.

That's the consensus based on intermediary medical review results, interviews with consultants and 157 responses to *HHL*'s new face-to-face encounter denials survey.

Of those survey respondents who received denials, 34.8% said they had received them for insufficient documentation to show skilled need and 27.2% received denials for insufficient homebound narratives. (*For more data from the survey, see insert.*)

Class action settlement raises the possibility of long-term care in home health

Welcome to the new world of home health. A proposed settlement in a class action lawsuit brought by Medicare beneficiaries could expand the kinds of patients your agency serves.

The beneficiaries contended they were unjustly denied benefits because their chronic conditions were not improving (*HHL 11/15/10*). Under the settlement terms proposed by the Obama administration, failure to show medical or physical improvement no longer will be grounds for denying Medicare beneficiaries coverage for home health care.

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MAHC tool is first-ever multi-factorial, validated falls risk assessment instrument

Your clinicians' OASIS workload just got a little lighter: Home health agencies will now be able to use a single tool that is both multi-factorial and validated to assess patients for falls risk and mark "yes" on M1910 (Falls risk assessment).

On Oct. 8, the Missouri Alliance for Home Care (MAHC) in Jefferson City announced that its falls risk assessment tool had been validated through a six-month study. The results of the study, which involved 10 freestanding, hospital-based, for-profit and non-profit Missouri home health agencies, were published in the Sept. 6, 2012 issue of the peer-reviewed journal *Home Health Care Management & Practice*.

The tool consolidates all of the major risk factors for a fall, such as age, visual impairment, environmental factors, poly-pharmacy and impaired functional ability, into a page-long checklist, says Mary Schantz, executive director at MAHC. Clinicians mark "yes" for each category that describes a patient, and patients are considered at risk of falls if they accumulate more than four "yes" answers.

The tool has taken some of the assessment load off registered nurses, giving them one less test to do and enabling them to focus on nursing-specific issues such as med review, says Valerie Bollinger, therapy director at

the VNA of Southeastern Missouri, one of the 10 agencies that participated in the study.

Independent data that MAHC collected from agencies using the tool suggests its effectiveness as well. In the first quarter of 2011, 85% of patients assessed with the tool were at risk for a fall. But following targeted interventions based on the risks the tool suggested, only 5% of patients actually experienced a fall, Schantz says. The study included 2,247 patients at an average age of 72.

Tool will 'level the playing field'

The emergence of a single tool for falls risk assessment is "wonderful," says Mary St. Pierre, VP for regulatory affairs at the National Association for Home Care & Hospice.

Before this tool, agencies had to use two different tools to meet OASIS-C requirements, one that was multifactorial and one that was validated, she says. In addition, agencies using the new tool will no longer be forced to answer "no" to question M1910 on the OASIS when treating wheelchair or bedbound patients, which will "level the playing field."

Guidance on M1910 in the OASIS-C Guidance Manual states that the "multi-factor falls risk assessment must include at least one standardized tool that 1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed and shown

to be effective in identifying people at risk for falls; and 2) includes a standard response scale."

However, keep in mind that it still is advisable to follow up on the MAHC tool assessment with an additional test, cautions Judy Adams, president of Adams Home Care Consulting in Chapel Hill, N.C. If the tool identifies a patient as a falls risk, it should be your practice to use the Timed Up and Go (TUG) or the Tinetti test to dig deeper into the cause of the patient's risk for falls, she says.

In fact, MAHC clarifies in its announcement of the validation study that the tool should be used "as an initial screen for fall risk, which if identified may warrant additional, more specific fall risk assessment."

Integrate the tool into software

MAHC is currently working with several vendors to integrate the tool into software systems, something that several of the agencies participating in the study have already done, Schantz says.

Do the following to make sure you're able to make use of the MAHC within your point-of-care system:

• **Contact your software vendor to determine whether the MAHC is already integrated or can be integrated easily.** At this writing, some software companies are waiting to confirm that their products can integrate the tool. For example, HealthWyse in Wilmington, Mass. is "well aware of" the tool and "is trying to get more specifics and do an assessment" of how the tool can be integrated, says Ellen O'Brien, senior director of marketing.

Agencies can already import the tool into Delta Health Technologies' home health software, says Keith Crownover, president of the Altoona, Pa. company. When Delta tried integrating the tool into its Crescendo product, it was able to do so within 30 minutes, Crownover says.

• **Make sure the content of the original tool isn't modified in any way when your vendor integrates it into the system.** Any change to the tool could impact its validity, Schantz says.

As the tool has been circulated for several years, agencies whose systems already include the tool also need to confirm that the tool they are using has not been modified or changed, she notes.

"Some agencies have embedded the tool with changes that they made to it and used it as their multi-

factor [falls risk] test, while using TUG as the validated tool," says Schantz. "Also, some vendors may have changed some of the wording on it. The 10 required core elements, along with the initial instruction, scoring mechanism and risk threshold *must* keep their specific wording or it's not the same tool, and thus not validated."

The validated tool is the one called MAHC-10 and its proper identification will be "embedded in the software," Schantz says. – *Danielle Cralle (dcralle@decisionhealth. com), Roy Edroso (redroso@decisionhealth.com) and Tina Irgang (tirgang@decisionhealth.com)*

Editor's note: *Find the original, validated version of the MAHC tool at www.homecaremissouri.org.*

Case study: Agency achieves efficiencies, fair productivity standards

An in-depth analysis of the daily workload for each coder has helped CHRISTUS Home Care in San Antonio eliminate one full-time equivalent (FTE) staff position from the department and create a solid baseline from which to judge staff performance.

The agency now is able to hold coders to a standard of completing between 15 and 21 records daily, says Laura Montalvo, director of quality management. Those benchmarks take into account everything the coders do and have enabled the agency to identify low performers and single them out for training or reassignment.

CHRISTUS Home Care currently employs 4.5 coders, who also audit records for the agency's 15 non-profit locations in Texas and Louisiana.

The incentive to conduct the analysis came when a consulting firm recommended significant layoffs in the department to realize cost efficiencies, Montalvo says.

Montalvo wanted to create a realistic picture of each coder's daily workload and show why the consultants' recommended productivity goal wasn't achievable in a home health environment, where many coders take on auditing responsibilities and other office tasks.

Agency captured all daily tasks

In July 2011, Montalvo and a data analyst began creating a process that would allow for realistic productivity measurement and tracking. The initial setup for this process took about a month, Montalvo estimates.

First, Montalvo sat down with all coders to get a comprehensive picture of their daily tasks.

The major issue for agencies trying to capture productivity is to make sure there is "a fair understanding of what the job entails," she notes.

Montalvo found that a simple measure of how many records coders completed wouldn't be enough. Coders spent a significant portion of each day making phone calls and conducting follow-up meetings with clinicians to reconcile discrepancies in the record.

Following the conversations with each staffer, Montalvo and the data analyst put their heads together and came up with a formula that they believed would capture the productivity of every member of the department, regardless of additional responsibilities or working hours.

The formula has been successful at showing how much work staffers actually do on a given day when compared to their colleagues, Montalvo says. As a result, it helped reassure the coders that the agency would make sure equal work was done for equal pay.

Analysis showed outsourcing effects

As a bonus, the system also showed that a move toward outsource coding wasn't working for CHRISTUS Home Care, Montalvo says. Productivity was suffering and non-coding tasks which employee coders had previously conducted weren't getting done as quickly, such as follow-up with clinicians on discrepancies in the record. Unlike for employee coders, auditing and corrections weren't part of the outsource coders' tasks, she notes.

As a result, CHRISTUS Home Care is now moving back to in-house coding and will soon hire two additional coders. Even taking those new coders into account, the agency is down one FTE compared to the time before Montalvo's analysis. The analysis helped show that the department really didn't need that FTE, she says.

Formula to measure productivity

Use this step-by-step process created by CHRISTUS Home Care to calculate and track productivity for your coders and record auditors:

1. Create a tracking log for each coder in Excel or using your software system. Each staffer should have a separate log for different agency locations and different service lines.

2. Use color-coding to show which records have been completed and which are late. CHRISTUS

Home Care uses red backgrounds for clinicians who haven't handed in documentation within 48 hours. This allows the agency to identify clinicians who are consistently late with documentation. Tracking logs are shared with directors of nursing at each agency location to give them an idea of how often clinicians' work is handed in late, Montalvo says.

Coders adhere to their own timeliness standard, which varies between 24 hours and five days depending on the coder's auditing workload and the software he or she works with. Records with coding delays receive an orange background.

The agency uses a grey background to indicate a record has been completed and locked.

3. Pull each coder's log or logs at the end of the month to create reports on the productivity for each staffer as well as the cost per audit for each staffer.

4. Calculate daily productivity for each staffer. CHRISTUS Home Care divides the total number of records in the monthly log by the number of days worked, minus any paid time off or holidays. The agency will make additional adjustments for other factors that influence productivity and are beyond the staffer's control, such as part-time schedules. This provides the agency with a fair productivity metric for each coder.

5. Calculate the cost per audit for each staffer to measure productivity in a way that shows actual dollar amounts your agency expends. Based on her conversations with the coders, Montalvo determined that about 75% of each staffer's time was spent on coding and auditing, with the remaining 25% spent on other tasks around the office, including the completion of tracking logs. As a result, Montalvo takes 75% of each staffer's monthly salary and divides it by the number of records completed that month. The cost per audit generally ranges between $6 and $20. – *Tina Irgang (tirgang@decisionhealth.com)*

Face-to-face denials

(continued from p. 1)

In addition to insufficient documentation, intermediaries also continue to deny claims because there was no encounter on recertification or there was no documentation for an episode in the first quarter of 2011 – neither of which is required, says William Evo, an appeals consultant and attorney with A.D. Maxim & Associates in Troy,

Mich. He also has seen denials for missing or inappropriate signatures and dates.

In fact, problems with signatures and dates are among the most prevalent uncovered by medical reviewers working for Medicare administrative contractor (MAC) CGS Administrators, said Annette Lee, a provider educator with CGS, during a Sept. 26 webinar.

The intermediary denied 41 claims for reasons related to face-to-face encounter documentation (reason code 5FFTF) between February and April of 2012 alone, making it the second-most common reason for denials after lack of medical necessity (reason code 5HMED).

CGS medical reviewers most often deny claims when the physician didn't date his or her signature at all or the date of the actual encounter was missing from the documentation. In some cases, the signature date was earlier than the date of the encounter, Lee noted.

However, narrative problems also have been the cause of denials, notably when physicians list only diagnoses to justify homebound status or skilled need. This can be acceptable in rare cases, such as when the diagnosis indicates a recent hip fracture, but agencies generally will be safer if they make it a standard rule not to accept diagnosis codes as documentation, Lee said.

Agency sees lack of MAC feedback

But in some cases, agencies are finding it hard to determine exactly why their claims were denied. Case in point: Medi Home Health Agency in Daytona Beach, Fla.

The agency so far has seen only three denials, a result that's mostly due to solid physician education using documentation examples, believes Mary Thornton-Webb, director of professional services.

Still, those denials are worth between $4,000 and $6,000 total, and the agency is appealing two out of the three, she says. The reason: While one of the claims was denied for insufficient homebound documentation, the agency's intermediary, Palmetto GBA, gave no clear reason for the denials on the other two.

"They just said the requirement wasn't met," Thornton-Webb says. "We thought [the documentation] was fine."

When Medi Home Health Agency appealed the denials to Palmetto, the intermediary declined to overturn them, stating again that the requirement hadn't been met. The agency now will try again at the second appeal stage.

Tips to help you prevent denials

Use these tips to prevent common face-to-face encounter documentation errors that can lead to denials:

• **Modify your prompt for the homebound narrative to improve responses.** It may be helpful to include the phrase "as evidenced by" in your prompt to get the physician considering what it is about the patient's condition that causes homebound status, Lee said.

• **Double-check dates on the face-to-face encounter form before submitting your claim.** Keep an eye out for physicians who date the encounter documentation prior to the actual encounter, Lee noted. If those two dates are reversed, it would result in a denial.

• **Staple a brightly colored half sheet with narrative examples to your face-to-face encounter form,** recommends Arlene Maxim, founder of A.D. Maxim & Associates. Maxim has noticed that physicians will quote portions of CMS' homebound requirements such as "it's a taxing effort to leave home," but will fail to relate those statements to the individual patient. (*For a copy of the half sheet, see insert.*) – Tina Irgang (tirgang@decisionhealth.com)

Class action settlement

(continued from p. 1)

The settlement now awaits final approval by a U.S. district court judge in Rutland, Vt., where the case was filed.

As part of the settlement, CMS would revise affected provider manuals to "clarify that SNF and HH coverage of nursing care does not turn on the presence or absence of an individual's potential for improvement from the nursing care, but rather on the beneficiary's need for skilled care."

One issue the settlement would leave undecided is whether the improvement standard used by CMS and its contractors was legal in the first place, given that CMS allegedly deviated from the government's established regulatory procedure by not proposing the standard for public comment before adopting it. The settlement means Judge Christina Reiss won't be ruling on that and other allegations, though the judge has expressed the belief that the outcome would have favored the beneficiary plaintiffs.

The Center for Medicare Advocacy in Willimantic, Conn. and Vermont Legal Aid represent beneficiaries in the case. In a statement, they declared the proposed settlement agreement will improve Medicare access "for tens of thousands of Americans, especially older adults and people with disabilities, whose Medicare coverage is denied or terminated because they are considered 'not improving' or 'stable.'"

Where will the money come from?

But benefits to patients aside, the agreement also has potentially troubling implications for the home health industry, consultants and agencies say. "Part of me is excited and part of me is scared," says Michelle Mantel, quality assurance manager at Gentiva Health Services' South Central Florida location in Plantation.

Medicare's home health costs might explode when what has been an intermittent benefit becomes one that covers ongoing services of the kind envisioned in the settlement agreement, says Ann Rambusch, president of Rambusch3 Consulting in Georgetown, Texas.

As a result of those new cost pressures, CMS may turn to a home health copay as a way to cover any funding gaps, Mantel believes. That would mean many chronically ill patients, who would otherwise profit from the settlement, may not be able to afford home health services.

Further home health rate cuts are also an option, Mantel believes. Such cuts could prove too much for small agencies, curtailing chronically ill beneficiaries' options for care, she says.

However, the change still could ultimately result in savings for the Medicare program, believes Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich. That's because chronically ill patients will likely experience fewer facility stays, which can cost between $1,500 and $2,000 per day, she notes.

What will medical necessity look like?

For now, it's unclear what medical necessity limits would look like under the revised coverage language. "I would think there have to be some criteria for an end point" to the home health episode, says Lisa Kidd, administrator of Baptist Home Health Care in Jacksonville, Fla.

The proposed settlement opens the door to long-term patients in home health, but until CMS publishes its revised manual language, it's impossible to know how the settlement will be interpreted in actual practice, notes Margarett Jelinek, national director of clinical operations for NurseCore in Arlington, Texas. "I don't know if I'm going to be changing anything until then."

CMS didn't respond to *HHL*'s request for comment on when agencies can expect the manual updates to be published.

Another concern: The agreement has increased the home health benefit's vulnerability to fraud in the form of "perpetual care," Rambusch believes. This, in turn, could cause Medicare auditors to further ramp up their already considerable scrutiny of home health, Mantel says.

The agreement is likely to affect many home health patients, Mantel believes. While agencies treat some patients with short-term needs, the majority have at least one chronic disease that, without the help of skilled clinicians, puts them on a path to decline, she notes. That includes, for example, Parkinson's patients, but also many with congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD).

As a result of the coverage changes, agencies are likely to provide a much larger amount of maintenance therapy, as well as evaluation and management services, Maxim believes. The evaluation and management benefit is designed for patients with multiple unskilled needs that must be supervised by a registered nurse.

Patients to have claims reexamined

As a result of the settlement, "many class members will have an opportunity to have their previously denied claims reviewed under the revised Medicare standards. Plaintiffs' attorneys will monitor and, if necessary, enforce the provisions of the agreement," the Center for Medicare Advocacy says in an Oct. 23 press release.

It's unlikely that most agencies and patients outside the class will be able to use the settlement to appeal past denials, Maxim says. That's due to time limits on appeals for past claims. However, Maxim says she plans to use the agreement when helping agencies appeal claims going forward. – *Tina Irgang (tirgang@decision-health.com) and Burt Schorr*

Independence at Home physicians: Meet our standards and share our dollars

Looking to join a partnership with other providers? Your agency might have to have acceptable outcomes scores, 24/7 caregiver availability and "specialty programs or services of distinction."

Those are only some of the criteria the Virginia Commonwealth University Health System's physician house calls practice in Richmond uses for considering home health agencies as partners in its Independence at Home program. The criteria are the first stage in a process intended to select a maximum of four agencies for the demo out of some 60 serving the area.

The Virginia experiment may be farthest along in selecting a few high-performing agencies as partners. However, you can expect other Independence at Home projects to reach out to home health, because Congress expressly intended program participants to partner with home health agencies, says attorney Jim Pyles of Powers Pyles Sutter & Verville in Washington, D.C.

In fact, a second Independence at Home participant, MD2U in Louisville, Ky., is currently taking similar steps to bring home health agencies into its program, says CEO Michael Benfield.

BENCHMARK of the Week

F2F denials: Number of denials and lost dollar amounts per agency

Most of the 157 agencies responding to *HHL*'s face-to-face encounter denial survey have seen fewer than five denials.

However, those agencies that did see denials report a significant impact to their bottom line, with some losing more than $30,000 to faulty face-to-face encounter documentation.

Q. How many denials have you seen for reasons related to the face-to-face encounter requirement?	
None	54.8%
Fewer than 5	33.5%
6-10	5.8%
More than 10	5.6%
Q. How much reimbursement have you lost as a result of all those denials combined?	
None	48.6%
Less than $1,000	4.3%
$1,000-$5,000	26.4%
$5,000-$10,000	10.7%
$10,000-$20,000	5.7%
$20,000-$30,000	2.1%
More than $30,000	2.1%

Source: HHL's *face-to-face encounter denial survey*

At least 20 RNs and 24/7 admissions

Winning agencies will need to have at least 20 registered nurses and provide the financial and staffing resources to admit patients 24/7 throughout the house calls service area, says geriatrician Peter Boling, head of the Richmond house calls program. They also must be willing to make visits to patients who aren't legally homebound but may need prescription adjustments or other attention short of standard home health to prevent a trip to the emergency room.

To make up for any additional costs, a selected agency could depend on a steady stream of patient referrals from the program and possibly be eligible for a portion of the bonus payments CMS offers Independence at Home participants based on program savings.

CMS will claim 5% of any savings achieved by Independence at Home programs, but allow the leading provider to keep 80% of the balance. The Richmond program intends to subcontract with four local agencies, but the agencies' cut of the gain-sharing bonus won't be decided until the volume of services they're providing is known, Boling says.

For patients who fall between the cracks

Even without a share of the CMS bonus, At Home Care, a 10-branch agency headquartered in Richmond, would welcome a formal link to the house calls program. The prospect of referrals by house calls practitioners "would be beneficial to our growth" and help chronically ill patients who now "fall between the cracks," says Barbara Wilson, clinical services director.

Participation in the program would be an opportunity to show house calls plus home health "are the most cost-effective model to care for chronic condition patients," believes Robyn Wandrick, administrator of Paradise Home Care in Richmond. In fact, she's convinced that such collaboration can cut costs by 50% and "change the industry as we know it."

One issue yet to be resolved is whether financial arrangements between a house calls practice and an agency might represent Stark or anti-kickback infractions, according to a CMS staffer. The authorization for the house calls demo specifically states it involves "primary care and not home health," the staffer notes. Should a primary care physician see fit to order home health, shared savings attributed to home health "at this point would not be part of the demo," the staffer insists.

However, attorney Pyles points out that the Affordable Care Act provision authorizing the demo states Independence at Home practices may include a "provider of services or a participating practitioner," who may share in savings. Moreover, to avoid potential Stark or anti-kickback problems, the law authorizes CMS to waive enforcement in both its Independence at Home and accountable care organization (ACO) demonstrations, Pyles notes.

Agencies looking to enter into Independence at Home partnerships have the following options, Pyles says:

• **Craft a share-in-savings agreement** that doesn't violate the Stark and anti-kickback laws or state corporate practice of medicine laws before entering into a partnership with another provider. This should be done with help from "knowledgeable legal counsel," Pyles says.

• **Ask for a waiver of the Stark and anti-kickback laws.** Congress and CMS clearly have indicated their intent and expectation that home health providers would be permitted to participate as part of Independence at Home practices and share in savings, Pyles contends. But if providers want an express waiver of the Stark and anti-kickback laws, CMS will provide it on a case-by-case basis, Pyles says he's been told by CMS staff. – *Burt Schorr (bschorr@decisionhealth.com)*

More specifics of the proposed class action settlement

• **Nursing services would be covered** "when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills" of a registered nurse or licensed practical (vocational) nurse are needed "to maintain the patient's current condition or prevent or slow further deterioration," according to the agreement.

• **Under the new standard, "the service must be so inherently complex** that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation (C.F.R. 409.32)."

• **CMS will disseminate the new policy** "in a nationwide educational campaign" involving written materials and interactive forums with providers and contractors. – *Burt Schorr (bschorr@ decisionhealth.com)*

Tool: Educational half sheet on face-to-face encounter documentation

Print the half sheet below on brightly colored paper and staple it to your face-to-face form to help physicians document correctly, recommends Arlene Maxim, founder of A.D. Maxim & Associates in Troy, Mich., who created the half sheet.

The face-to-face encounter narrative must be a separate and distinct section of or addendum to the physician's orders/485 and must include the following:

1. Patient name and identification (If not located on the document)

2. A certification narrative that outlines:

   i. The date of the in-person visit with a physician or non-physician practitioner (nurse practitioner, clinical nurse specialist or physician's assistant) and that the visit was related to (completely or in part) the medical condition for which the patient needs home health services

   Example: "This patient was seen in my office on July 2, 2012 for COPD, which is the current reason that we have ordered home care."

   ii. The services requested (nursing and/or physical therapy and/or speech language pathology) are medically necessary and support the need for the requested home health services.

   Example: "My clinical findings support the need for both skilled nursing and physical therapy services. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new COPD medical regimen. These services are medically necessary. This patient has gained more than 6 lbs in one week, has increased SOB and significant muscle weakness. We are concerned about her compliance with new medications."

   iii. The patient is homebound (He/she requires considerable and taxing effort to leave the residence. Absences from home are for medical reasons or religious services. Absences are infrequent and of short duration.)

   Example: "Based on my clinical findings, this patient is homebound due to extreme dyspnea limiting her ambulation. This patient is currently walker dependent related to muscle weakness. PT is needed to restore the ability to walk without support."

3. A statement indicating the patient is under a physician's care and the in-person visit was conducted by a physician or non-physician practitioner and meets the requirements for a face-to-face encounter.

   Example: "I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements."

4. The certifying physician's signature and the date indicating WHEN the narrative was signed.

Narrative errors top the list of denial reasons

Of 157 agencies who responded to *HHL*'s recent survey, 47.4% indicated they had received at least one denial relating to the face-to-face encounter requirement.

The data below break down the reasons those denials were received. (*For more on the most common denial reasons, see story p. 1.*) The most frequent reasons cited in the "other" category were illegible signatures and denials where the specific reason was unclear.

Q. What were the reasons for [your face-to-face encounter] denials? (Check all that apply.)	
Insufficient documentation to justify skilled need	34.8%
Insufficient documentation to justify homebound status	27.2%
Missing face-to-face encounter documentation	25.0%
Encounter outside of specified timeframes	12.0%
Missing or wrong date	12.0%
Missing or wrong signature	6.5%
Other, please specify	33.7%
Source: HHL's face-to-face encounter denial survey	

CGS Administrators provides details on hospice widespread edits

Medicare administrative contractor (MAC) CGS Administrators responded to *HHL*'s request for comment on the scope of its widespread hospice edits with the following information:

There are five widespread topic edits on for hospice providers billing to CGS. These edits have been through an initial probe process that included the selection and review of 100 claims for the topic. Each of these current edits were found to have a high denial rate, and therefore, implemented as a widespread edit. Edits are analyzed each quarter for efficacy. When a claim has the same parameters as the edit (such as the length of stay is > six months, and a diagnosis such as COPD), any provider might have a claim selected for an additional development request (ADR). These edits are not provider specific.

The list of current edits can be found on the CGS website at: *https://www.cgsmedicare.com/hhh/medreview/med_review_edits.html*. This list is updated routinely when new edits are added or changed.

The table below shows the widespread hospice edits between Oct. 1, 2011 and Sept. 30, 2012, including the edit parameters and the number of claims ADR'd. During this timeframe, 549 unique providers had claims selected for a widespread edit.

Edit	Edit Parameters	# of ADRs (10/1/11 – 9/30/12)
5011T	This edit selects hospice claims with primary diagnosis 294.8 (other persistent mental disorders due to conditions classified elsewhere), and at least 28 units billed, and a length of stay greater than 240 days.	24
5011W	This edit selects claims with a length of stay greater than six months, and a primary diagnosis of 331.0 (Alzheimer's disease), 799.3 (debility), or 496 (COPD).	107
5037T	This edit selects hospice claims with revenue code 0651 (routine) and a length of stay of greater than 730 days.	927
5048T	This edit selects hospice claims based on a length of stay of 999 days.	295
5057T	This edit selects hospice claims with revenue code 0656 (general inpatient services [GIP]) with at least seven or more days in a billing period.	416
5091T	This edit selects hospice claims with HCPCS codes Q5003 (hospice care provided in nursing long term care facility [LTC] or non-skilled nursing facility [NF]) and Q5004 (Hospice care provided in skilled nursing facility [SNF]), primary diagnosis of 799.3 (Debility, unspecified) and a length of stay greater than 180 days.	721
5101T	This edit selects claims with a length of stay greater than 180 days, and a primary diagnosis of 331.0 (Alzheimer's disease), 799.3 (debility), or 496 (COPD).	3,923