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Want in on an ACO? Don't expect MedPAC to support home health's involvement

Agencies that want a seat at the accountable care organization table should be prepared to make the case that home health is more cost-effective and appropriate for patients than other provider settings.

Whether CMS will say that when it adopts ACO criteria next year is an open question. But the Medicare Payment Advisory Commission (MedPAC) is preparing ACO advice for CMS along those lines.

The authorization for ACOs in health care reform doesn't specify which providers should participate (*HHL 10/11/10*).

The challenge for agencies will be to show how their care is more cost-effective than outpatient rehab, skilled nursing facilities or other post-acute settings, an Oct. 7 MedPAC staff presentation suggests.

(continued on p. 8)

CMS collects comments on compliance programs' costs and electronic tracking

Do you use electronic data in the form of spreadsheets or sophisticated software to evaluate the effectiveness of your compliance program?

CMS is collecting comments about that concept in the latest proposed rule published Sept. 23. The proposed rule also seeks comments on the cost and burden of developing a compliance program and whether the seven elements of compliance identified in U.S. Sentencing Guidelines should be required (*see box, p. 3*).

2011 PPS final rule coming soon

The 2011 PPS final rule is expected on Oct. 22. Prepare for face-to-face encounter requirements and new therapy rules at www.decisionhealth.com/conferences/A2037.

As for electronic data, it's unclear what compliance components CMS wants to measure. It could be a year-to-year tracking of survey deficiencies or staff participation in compliance training, for example, says Carol Saul, attorney and partner at Arnall Golden Gregory in Atlanta.

Using electronic data to measure the effectiveness of compliance programs will be new for most home health agencies, she says. The level of sophistication required for the system could vary depending on the size of the agency, Saul says.

The proposed rule also implements several health care reform provisions related to screening and enrollment (*HHL 10/4/10, 9/27/10*).

Providers can submit comments on:

- **The costs and benefits of compliance programs.** The federal agency likely wants to estimate the resources needed to implement such requirements, says home health attorney Elizabeth Pearson of Pearson & Bernard in Edgewood, Ky.
- **Timeline for establishing mandatory compliance programs,** which could vary by types and sizes of providers, the rule states. CMS says that compliance program requirements will not be part of this upcoming final rule. Instead, specific proposals related to mandatory compliance programs will be released "at some point in the future."

That could mean CMS is "a ways from having something complete," says home health attorney Robert Markette of Gilliland & Markette in Indianapolis.

- **Overlap with state compliance program requirements.** CMS wants to know what existing compliance program requirements agencies already must adhere to that might be in conflict with or duplicated by federal rules. That seems to be a reference to New York state's requirement that providers have compliance programs to participate in Medicaid, Saul says (*HHL 9/6/10*).

- **Groups of providers that should have similar compliance requirements.** Markette suspects CMS is looking for confirmation that different provider types should have different compliance obligations. Compliance program requirements for home health agencies need to address clinicians working in the field; compliance program requirements for hospitals need to address employees working in the facilities, he notes as an example.

- **Corporate versus individual compliance responsibilities.** CMS wants to know "whether individuals should have different compliance obligations from corporations," the proposed rule states.

- **Use of third-party resources, such as consultants and auditors.** – Karen Long (klong@decisionhealth.com)

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Solidify hospice documentation for cancer codes or risk denials

Almost 60% of hospice claims submitted to Cahaba GBA with 202.xx (lymphomas) or 203.xx (myelomas) as the primary diagnosis for patients on service more than 180 days were denied.

But you can avoid that denial by making sure that a patient's lymphoma has metastasized and documenting that.

Cahaba GBA denied 58.7% of those claims because of insufficient documentation to support the six-month prognosis, according to the intermediary's September newsletter. (*For more about the denial rates, see chart, p. 4.*)

The intermediary's local coverage determination (LCD) specifies that for patients with cancer diagnoses to be eligible for hospice, they must have:

- Distant metastases at presentation or
- Progression from an earlier stage to a metastatic stage with continued decline in spite of therapy or patient declines further disease-directed therapy.

But some hospices admit patients with lymphomas or myelomas before the disease had metastasized and become terminal, says Phyllis Rust, associate with The Corridor Group. They fail to confirm the diagnosis with the patient's physician or obtain lab results, which could justify the patient's eligibility.

In February 2009, Cahaba implemented a widespread edit for claims of patients on service for more than 180 days with 202.xx and 203.xx as the primary diagnosis, the intermediary states in its newsletter. That means payments for all claims with those codes as a primary diagnosis for patients on service more than 180 days are suspended until supporting documentation can be checked, the intermediary states.

Palmetto GBA does not have similar edits in place, a spokesman tells *HHL*. NGS did not respond to *HHL*'s request for information.

Vascular dementia under scrutiny

Another hospice primary diagnosis that Cahaba is examining is 290.40 (vascular dementia) when the patient has been on service for more than 240 days, the intermediary's newsletter states. Cahaba denies 62.8% of claims that meet those criteria.

Documenting the hospice eligibility of patients with vascular dementia can be difficult, Rust says. While

7 elements likely will be required in mandatory compliance programs

CMS also wants to hear from providers whether they incorporate in their plans the seven elements of effective compliance programs described in the U.S. Federal Sentencing Guidelines and reiterated in the Office of Inspector General's 1998 compliance guidance to home health agencies.

"I think they're seriously considering just going with the seven elements," says home health attorney Robert Markette of Gilliland & Markette in Indianapolis.

The elements are:

- Adopt written policies and procedures,
- Designate a compliance officer,
- Exclude people who have engaged in illegal activities,
- Train staff regularly,
- Maintain a hotline or method for reporting noncompliance,
- Have a process to respond to allegations of noncompliance,
- Conduct audits and remedy problems with compliance.

CMS should leave enough flexibility in the requirements that agencies can adopt them to fit the culture of the organization instead of just cutting and pasting into their compliance programs, says home health attorney Elizabeth Pearson of Pearson & Bernard in Edgewood, Ky. – *Karen Long* (klong@decisionhealth.com)



Helpful Links:

CMS is accepting comments on the proposed rule until Nov. 16. To comment, visit www.regulations.gov and follow the "submit a comment" instructions.

hospices might think they should follow the section of the Cahaba's hospice LCD for "dementia due to Alzheimer's disease and related disorders," it might not be the best guideline because vascular dementia follows a different pathway, she adds.

To document the hospice eligibility of vascular dementia patients, Rust suggests that hospices:

- **Take into account the general decline in clinical status guidelines**, not just the dementia section of the LCD. Those guidelines include documenting worsening clinical status such as weight loss and decreasing abdominal girth, increased emergency room visits and decreasing ability to complete activities of daily living.

- **Document respiratory impairments** as well as whether the patient has difficulty swallowing, aspiration pneumonia or pyelonephritis.

- **Include only comorbidities that affect and contribute to the prognosis.** Diabetes would not support medical necessity for a diabetic patient whose disease has been stable for 20 years.

More tips to prevent hospice denials

- **Document results of objective testing.** Use tests such as the Karnofsky performance status or palliative performance score to measure patients' functional abilities, suggests Lynda Laff of Laff Associates in Hilton Head Island, S.C. Give the patient the tests on a regular basis, such as weekly, and compare results to show the patient's decline, which is essential for supporting hospice eligibility.

- **Consider discharge if the patient is not declining.** Discuss the patient's status among members of the interdisciplinary group. In some cases, such as pancreatic cancer, the patient might seem to improve for a short time, but the disease's poor prognosis might indicate the improvement is temporary (*HHL 12/21/09*).

– Karen Long (klong@decisionhealth.com)

 **Helpful Links:**

To see Cahaba's LCD for determining hospice eligibility, log onto www.cms.hhs.gov/mcd/overview.asp and search for L13653.

CMS postpones claims denials related to physician PECOS enrollment

Agencies won't start receiving PECOS claims denials until July 1, 2011.

Starting Oct. 1, agencies started receiving informational edits on their claims when physicians aren't enrolled in Provider Enrollment Chain and Ownership System (PECOS) (*HHL 9/27/10*).

The new claims denial start date marks the second time that CMS has delayed that requirement. Originally, denials were set to begin July 6, 2010, but that deadline was pushed back to January after industry reports stated that 70% of physicians were not enrolled in PECOS (*HHL 6/21/10*).

What to look for on informational edits

- **Look for remark code N272 (missing/incomplete/invalid other payer attending provider identifier) on your edited claims.** If that code appears on your claims, it means your referring physician's information was not found in PECOS or the physician is not of the specialty needed for the referral, CMS says in a memo to providers.

- **Double-check your referring physician's enrollment status.** If the physician is enrolled, make sure you've listed his or her National Provider Identifier

Benchmark of the Week

Denial rates for Cahaba GBA's widespread edits of hospice claims

This table shows the denial rates for hospice claims with 202.xx or 203.xx as the primary diagnosis for patients on service more than 180 days.

It also shows the denial rates for hospice claims with 290.40 as primary diagnosis for patients on service more than 240 days.

The intermediary has both as widespread edits, meaning your payments will be suspended until Cahaba can check your documentation (*see related story, p. 3*).

Widespread edit	5065T	5013T
Primary diagnosis on claim	202.xx – 203.xx (lymphomas and myelomas)	290.40 (vascular dementia)
Length of stay	More than 180 days	More than 240 days
Denial rates	58.7%	62.8%
Level of services	Routine	Routine
Edit start date	February 2009	October 2007

Source: Cahaba GBA's Sept. 1, 2010, edition of "Home Health & Hospice Medicare A Newsline"

(NPI) number and name correctly on the claim. If he or she is not enrolled, check with the physician's office to see whether he or she has a pending enrollment application, the National Association for Home Care & Hospice recommends. – *Tina Irgang (tirgang@decisionhealth.com)*

Digital pens ease transition to electronic records for Dallas agency

As agencies nationwide struggle to transition from paper-based to electronic records, Home Healthcare Partners in Dallas has found the most efficient solution is to stick with paper and pens – digital pens.

The digital pens, offered by Anoto AB in Westborough, Mass., work like regular pens. Clinicians use them to fill out paper documents, such as OASIS-C forms and visit notes. The difference: As clinicians are writing, the digital pens capture a photo of the handwriting. And when clinicians dock the pens in their chargers at the end of the day, the information is uploaded to the agency's server.

By choosing digital pens over laptops or handheld devices, the agency saved \$6,455.40 per nurse related to reduced staff training time and prevention of lost productivity, says SuZanne Merrifield, project manager for the pen implementation at the agency's six branches serving approximately 4,400 patients in Louisiana and Texas.

Merrifield says it took only two hours to teach clinicians how to use the pens, compared with the 60 hours of training the agency's IT department budgeted if it had instead chosen laptops.

Another advantage of the pens is that they are small and mobile. And, unlike laptops, they don't interfere with the face-to-face encounter the patient is having with the clinician. "The pens don't have a user interface that (clinicians) can get lost in," taking their attention away from patients, says Matt Willson, managing director of Austin, Texas-based Datalytics, which supplied the pens to the agency.

Patient data are protected against Health Insurance Portability and Accountability Act (HIPAA) violations, because all of the data are encrypted, says Merrifield.

Low costs for startup, staff training

The benefits of using the pens far outweigh the costs.

The initial start-up fee for agencies to rent the pens is fixed at \$275, which covers pen setup and the accompanying agency software, says Willson. Agencies also pay a monthly fee up to \$44 for technical support and licensing costs.

Currently, Home Healthcare Partners rents about 200 pens, which are used by nearly half the agency's clinicians. Eventually the agency plans to provide pens to all clinicians, Merrifield says. The response has been positive from staff members, and clinicians are eager to get their pens back if something breaks.

The hardest thing for clinicians to get used to was how to identify the pen's low-battery power or full-storage capacity alerts. The pens light up and make a buzzing sound to let the user know when either happens.

Digital pens recognize handwriting

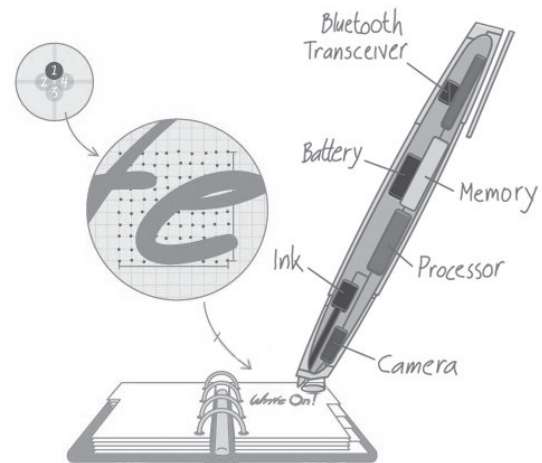
The digital pen technology was patented by Swedish company Anoto in 1999 and links up with a software application supplied by Datalytics. The software prints a subtle, light black dot pattern onto the background of every form an agency prints out.

To the naked eye, that dot pattern looks like shading on the form. But the digital pens read the dots to determine which form is being completed and how to store the information.

Because the digital pen contains an ink cartridge, the completed form can serve as back-up if a pen breaks, says Virginia Carpenter, vice president of marketing for Anoto. – *Tina Irgang (tirgang@decisionhealth.com)*

Digital pens, an alternative to laptops

This image shows the components of the digital pen from Anoto, AB Westborough, Mass. The pens capture a picture of the forms as nurses complete them. The information is stored in the pens and later uploaded into the agency's software.



Source: Graphic by Anoto AB, Westborough, Mass.

New CMS chief has experience with home health care transitions

Physician Richard Gilfillan, who has been chosen to head CMS's new Center for Medicare and Medicaid Innovation (CMI), sees an important role for home health in the coming era of integrated transitional care.

Under health care reform law, the center has the key job of testing "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing quality of care" (*HHL 8/23/10*).

As the former CEO of Geisinger Health Plan, headquartered in Danville, Pa., Gilfillan directed the development of the ProvenHealth Navigator (PHN) program. That program includes 205 home health agencies across Geisinger's 40-county service area.

The four-year-old program features a continuum of acute and post-acute care directed by its 61 case managers. Stationed at 35 Geisinger physician practice sites and five non-Geisinger sites, the case managers are available 24 hours a day, seven days a week to monitor and guide as many as 150 Medicare and privately insured patients diagnosed with chronic heart failure, diabetes or coronary artery disease.

Also available to help with the most at-risk patients are some 1,500 patient-monitoring units that report weight gains, glucose changes and other warnings about the patient's condition.

Medical Home helps care coordination

To Karen Adams, director of 300-patient Geisinger Home Care, the Medical Home program is saving the hours otherwise needed to get physician approval for care plan changes.

Typically, the case managers have worked out advance contingency plans with members of the physician practices where they're embedded. By working closely with them, the agency's 20 full-time clinicians can get plan changes approved in minutes, Adams notes. And because the ProvenHealth Navigator program also offers access to patient records for all participating providers, Geisinger Home Care nurses can see hospital discharge plans.

The unified patient records system also has enhanced the agency's ability to identify discontinued prescriptions and potential medication interaction problems. Prescription and dosage corrections now can occur as quickly as the

few minutes needed to reach the patient's case manager, rather than the day or more it might take if the request were left with the physician office receptionist, Adams says.

Case managers in the program:

- **Educate the patient and the patient's family** about the patient's condition.
- **Work with hospitalized ProvenHealth Navigator patients** to make sure the transition from hospital to nursing home or private home is smooth.
- **Make sure patients are scheduled for necessary follow up-care** with their primary care provider or specialist.
- **Help to arrange any necessary social or medical services**, such as transportation, home health or medical equipment.
- **Reconcile medications to prevent errors.** As of last fall, ProvenHealth Navigator protocols led to 23% fewer hospital admissions and re-admissions than a control group of non-Geisinger Medicare patients, nearly 9% fewer ER visits and 17% fewer inpatient stays, Geisinger reports. Also, total care costs per program member per month were about 3% lower. – *Burt Schorr* (bschorr@decisionhealth.com)

Second home health jurisdiction is transitioning from RHHI to MAC

The second of four home health jurisdictions is about to transition from a regional home health intermediary (RHHI) to a Medicare administrative contractor (MAC).

The Government Accountability Office (GAO) struck down a bid protest in September giving home health jurisdiction C the go-ahead to begin the transition to its MAC.

Fresh ideas for growing referrals

Come to the **10th Annual Power Home Health Referrals Conference** on Feb. 23-25, 2011, in Las Vegas. New this year: We've added a hospice-specific track to teach agencies how to avoid hospice marketing pitfalls, overcome obstacles to appropriate hospice admissions and create palliative care programs. Register today at www.powerreferrals.com and save \$100!

The transition for that area, which includes most of the states in the South and the West, is expected to take place by early 2011 (*see below for a list of states*). Palmetto GBA, which previously served that region as the RHHI will take over as the MAC and foresees “minimal operational changes,” the intermediary said in an email to *HHL*.

Smooth transition for NE agencies

The only home health area that has completed the transition to a MAC is jurisdiction A in New England. That jurisdiction covers Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. So far, agencies there have reported a relatively smooth transition.

National Heritage Insurance Corporation was awarded the MAC contract for that jurisdiction in November 2008 and assumed full responsibility as the region’s MAC in June 2009.

Home health associations in those states reported hearing no complaints from agencies about delayed claims audits or payments during or after the MAC takeover.

Other transitions stalled by bid protests

As for the other jurisdictions, CMS says it’s on track to meet the Oct. 1, 2011, deadline for transitioning all MACs.

Here’s an update on the implementation status for the remaining three jurisdictions.

• **Jurisdiction B is currently under bid protests.**

States and districts include Colorado, Delaware, District of Columbia, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota,

Utah, Virginia, West Virginia and Wyoming. CMS awarded the MAC contract for this jurisdiction to CIGNA Government Services in June, but Highmark Medicare Services, Cahaba GBA and National Government Services have filed protests. The Government Accountability Office’s decision on those protests is due by Nov. 3.

• **Jurisdiction C’s contract has been awarded.**

States include Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee and Texas. CMS awarded that contract to Palmetto GBA in May 2010, but CIGNA Government Services filed a protest against the award. On Sept. 9, GAO denied that protest, meaning Palmetto can now move forward with assuming the MAC workload for jurisdiction C.

• **Jurisdiction D’s bid is being rewritten by CMS.** States include Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, U.S. Virgin Islands, Wisconsin and Washington. In January 2009, CMS awarded that contract to Noridian Administrative Services. National Government Services, Wisconsin Physicians Insurance Corporation and Palmetto GBA filed protests and CMS is currently rewriting the bid to avoid future delays. CMS said it could not comment on the nature of the corrections. – *Tina Irgang* (tirgang@decisionhealth.com)

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Average post-acute care spending by provider type

This table breaks down the average cost per patient to receive care after being discharged from post-acute care (PAC), according to a recent MedPAC analysis of CMS claims data (*see story, p. 1*).

Hospital condition	Avg. PAC cost (2004-2006)	Outpatient rehab	Home health	SNF	Rehab Facility	LTC hospital
Stroke	\$10,680	\$569	\$2,478	\$8,527	\$18,923	\$22,070
Hip & femur procedures for trauma	\$10,392	\$1,217	\$2,595	\$8,761	\$16,018	\$22,738
Cardiac bypass with catheterization	\$5,230	\$837	\$1,778	\$5,737	\$14,631	\$24,526
Heart failure	\$4,144	\$612	\$1,611	\$6,462	\$14,698	\$20,236

Source: Medicare Payment Advisory Commission (MedPAC) based on CMS claims data from 2004 through 2006

CMS to states: Medicaid RACs must be fully operational by April 2011

New Medicaid recovery audit contractors (RACs) aren't expected to focus their attention on home health, but agencies could feel the effects of their reviews in another way.

The Medicaid RACs will be paid a percentage of overpayments they identify and could focus on big-ticket providers, such as hospitals and physicians, speculates home health attorney Robert Markette of Gilliland & Markette in Indianapolis. That might free up state Medicaid investigators to look for overpayments to other types of providers, such as home health agencies, he says.

"Either way, you end up with more audit resources than before," Markette notes.

Medicaid RACs, required by the health care reform law, must be established by the end of the year and fully implemented by April 1, 2011, CMS tells state Medicaid directors in an Oct. 1 letter.

Medicaid RACs paid by contingency fees

Just like the federal program, states will pay Medicaid RACs contingency fees for identifying overpayments.

And also like the federal program, RACs likely will go after high-dollar claims unless states specify in RAC contracts that the reviewers should target certain provider types, such as home health, Markette says.

More guidance for states, including which personnel the RACs are required to have and what the look-back period will be, will come out in future rulemaking, CMS says in the letter. – Karen Long (klong@decisionhealth.com)

Want in on an ACO?

(continued from p. 1)

Medicare's conditions of participation "do not clearly delineate which patients belong in which settings," MedPAC staffer Carol Carter pointed out. As a result, post-acute care referrals are driven by "hospitals' ownership and contracting relationships, the supply and availability of a bed at the time of discharge, not necessarily patient care needs," Carter noted.

CMS is trying to develop a patient-assessment tool to decide the most appropriate post-acute care setting (*HHL 4/19/10*). In the meantime, the fear is that participating ACO providers will be left to decide which provider to refer to.

In terms of Medicare costs alone, home health enjoys the fact that only outpatient rehab is cheaper. A MedPAC staff analysis based on claims data from 2004 through 2006 found that post-acute care for stroke patients cost Medicare an average \$10,680, for example, compared with an average home health cost of \$2,478 (*see table, above*) – Burt Schorr (bschorr@decisionhealth.com)

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