

HOME CARE WEEK™

News & Analysis On Reimbursement, Regulations, Finance, Operations, & Compliance

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& suggestions!

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Fraud & Abuse

Health Care Reform Brings Major Compliance Changes

One guilty-until-proven-innocent provision will shutter some blameless providers, expert says.

Under the health care reform law's tough new fraud-fighting provisions, regulators will take your money first and ask questions later.

"The [HHS] Secretary may suspend payments to a provider of services or supplier ... pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments," says the Patient Protection and Affordable Care Act (PPACA).

The **Department of Health and Human Services** will "consult with" the **HHS Office of Inspector General** to determine whether the allegation of fraud is credible and therefore triggers the suspension, continues the legislation that **President Obama** signed into law March 23.

Timeline: The law contains no implementation date for this provision, but does direct HHS to publish regulations about the change.

This provision finds the provider guilty without a trial, protests consultant **Tom Boyd** with Rohnert Park, Calif.-based **Boyd & Nicholas**. Because providers get "no cash while waiting for clearance," he notes, the provision could close some innocent providers' doors forever.

The payment suspension provision is just one of many fraud-fighting initiatives included in PPACA. The Obama administration expects the law's fraud and abuse measures to raise millions to pay for overall health care reform.

Other PPACA compliance provisions that will most affect home care providers include:

- **Compliance programs.** As-yet-unspecified Medicare providers must establish a compliance plan "as a condition of enrollment" in Medicare, PPACA says. HHS and the OIG in conjunction will establish "core elements" for the required compliance program.

HHS has discretion on which providers will fall under this requirement and what their deadline will be, according to the law. But home care providers are likely to top the list, experts agree.

Durable medical equipment and home care "are two industry sectors that the HHS may priori-

tize in establishing mandatory compliance program requirements," predicts law firm **Morgan Lewis** in an analysis of the new provision. That's due to "the relatively low rate of compliance program adoption by ... DME and home health, as compared to other industry sectors, such as hospitals and health systems," the firm notes. The law and the **Centers for Medicare & Medicaid Services'** focus on enrollment requirements for DME and home health also may be a good indicator.

Small providers are likely to feel the burden of this provision the most, Morgan Lewis expects. That's because "many, if not most, larger health care providers already have some form of compliance program."

The **American Association for Homecare** plans to share the code of ethics it has been developing, which should help suppliers meet the compliance plan requirement, the trade group says.

- **Repayment timeliness.** Providers must return any overpayments within 60 days of identifying them, the law spells out. If providers knowingly fail to return overpayments by the deadline, they are subject to False Claims Act-level penalties — treble damages and fines, notes **BKD's Tom Watson** on the firm's website.

Watch out: The law sets the deadline for this provision as May 22, Watson warns. "Providers that may be aware of known or potential overpayments should carefully assess their repayment obligations prior to that date to avoid possible FCA provisions," he urges.

CMS hasn't yet defined what the definition is for "identification" of overpayments, Watson adds. Stay tuned to forthcoming CMS regulations for more details.

- **False claims liability increases.** PPACA makes some dramatic changes that will increase false claims liability. For one, penalties for kickback violations will increase. "A claim that includes items or services resulting from a [kickback] violation ... constitutes a false or fraudulent claim," the law says. "A person need not have actual knowledge of this section or specific intent to commit a violation of this section."

Secondly, as of March 23, the reform legislation "lifted the bar for *qui tam* relators to use public documents to bring a whistleblower lawsuit under the *qui tam* provisions in the False Claims Act," reports attorney **Neville Bilimoria** with **Duane Morris** in

Audits

Medicaid RACs Slated To Fire Up This Year*Will the new Medicaid bounty hunters duplicate MIC scrutiny?*

If you submit claims to Medicaid, get ready for another set of eyes looking over your shoulder.

The Patient Protection and Affordable Care Act (PPACA) calls for every state Medicaid program to contract with at least one Recovery Audit Contractor to review claims. That totals a minimum of 56 Medicaid RACs, points out consultant **Tom Boyd** with Rohnert Park, Calif.-based **Boyd & Nicholas**.

Like their federal counterparts, Medicaid RACs would be paid on a contingency fee basis. That means their fee would be based on a percentage of the funds they recover. However, they also would receive a set fee for cases in which they find underpayments, adds the health care reform law that was enacted in March.

Health care providers have roundly criticized this bounty hunter model of payment, which encourages RACs to make unnecessary recoupments, they say.

The new Medicaid RAC requirement “adds one more auditor,” observes attorney **Robert Markette Jr.** with **Gilliland & Markette** in Indianapolis. And if the Medicaid RACs use statistical sampling and extrapolation, the reimbursement hit to providers could be severe.

Medicaid RACs Could Step On MIC Toes

Medicaid RACs also may duplicate efforts already underway by the Medicaid Integrity Contractors (MICs). In some states, MICs already have been targeting hospice claims for review, relates consultant **Heather Wilson** with **Weatherbee Resources and Hospice Education Network** in Hyannis, Mass.

One difference: However, MICs are not paid on a contingency basis, Markette points out. That could mean MICs would be more likely to go after home care providers, because the overall dollar amount isn't as high of a priority in establishing targets for scrutiny.

If the Medicaid RACs follow the federal RACs' example, home care providers may not have much to worry about from the program for a while. That's because the federal RACs still haven't established any home health agency or hospice-specific audit topics, the **Centers for Medicaid & Medicaid Services** confirmed in a May 4 educational conference call.

However, Medicare RACs have established a score of durable medical equipment topics. And they've established topics that relate to home care, such as bundling of items and services in home health consolidated billing and hospice payments (*see Eli's HCW, Vol. XIX, No. 9, p. 67*).

Medicaid RACs may be more willing to look into home care claims, too, particularly if the state has a high level of spending on the program, experts predict.

Hopefully PPACA's requirement for Medicaid RACs to coordinate with other auditors will reduce the number of duplicative audits providers will see under the program, Markette notes.

But the law's requirement for the Medicaid RACs to coordinate with law enforcement officials could mean more scrutiny, Markette adds. In the wake of the **Government Accountability Office's** report criticizing the Medicare RAC demonstration program for producing few fraud referrals (*see Eli's HCW, Vol. XIX, No. 15, p. 118*), CMS may take pains to ensure fraud referrals occur when appropriate. ❖

Chicago. Previously, the whistleblower had to be the original source of the information about the provider, he adds. “If surveys can be used as a basis for a *qui tam* lawsuit — look out,” he warns.

The repayment timeliness provision (*see previous page*) also increases FCA liability.

These changes “reverse the recent judicial trend toward limiting FCA *qui tam* actions,” notes

law firm **Gibson Dunn** on its Web site. They “will likely increase both the number and type of whistleblower suits.”

• **Documentation.** You finally are receiving a helping hand in getting referring physicians to cough up necessary documentation for medical review. But if your documentation or response to

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medical review is sloppy, it could be you on the chopping block.

HHS “may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier ... if such physician or supplier fails to maintain and ... provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services,” the law spells out.

Already in place: The effective date of this provision is retroactive to Jan. 1, 2010, PPACA says.

- **Screening.** The law requires screening of providers. HHS will “determine the level of screening ... according to the risk of fraud, waste, and abuse” in the industry, PPACA says. That surely will put home care providers at the top of the screening list, industry observers expect.

Screening will include a licensure check and might also include a criminal background check, fingerprinting, unscheduled and unannounced site visits (including pre-enrollment ones), database checks, and others.

Providers will have to pay for their own screenings, to the tune of \$500 for institutions and \$200 for individuals, the law says. Those rates will be adjusted upward for inflation going forward.

This provision takes effect in September.

- **Enrollment safeguards.** PPACA calls for other preventive measures such as revalidation of enrollment information (which many home care providers already have undergone); increased initial oversight of new Medicare providers; and disclosure of current or previous affiliations with providers that have or had certain payment problems. Those problems include uncollected debt, payment suspension under a federal health care program, exclusion from participation, or billing privilege denials or revocations.

HHS can also declare a temporary moratorium on enrollment of new providers if HHS “determines such moratorium is necessary to prevent or combat fraud, waste, or abuse,” the law says.

- **Surety bonds.** HHS must take suppliers’ and agencies’ volume of billing into account when calculating amounts for surety bonds, PPACA says.

What surety bond requirement? HHAs do not currently have a surety bond requirement

enforced, but the legislation refers to bonds for home health agencies too.

- **Recoupments.** When entities share a tax ID number, CMS can adjust payments for one entity based on another entity’s “past due obligations,” PPACA says. This is true “regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program.” ❖

Reimbursement

PECOS Edits Hit HHAs, Suppliers At Same Time

You can't use your own NPI in the physician field starting this fall.

You could see your cash flow fall into serious jeopardy starting in the new year if you have referring physicians who aren’t enrolled in Medicare’s PECOS system.

That’s because the **Centers for Medicare & Medicaid Services** is subjecting home health agency claims to the same Medicare Provider Enrollment Chain and Ownership System (PECOS) edits that durable medical equipment claims are currently undergoing, as required in the Patient Protection and Affordable Care Act (PPACA). The requirement is in the Social Security Act, CMS says in April 28 Transmittal No. 677 (CR 6856).

The edits will “verify the attending physician provider on an HHA claim is eligible and is enrolled and active in the Medicare program’s Provider Enrollment, Chain and Ownership System (PECOS),” the transmittal says. “This means providers who are enrolled in the Medicare program must be in the PECOS in an approved or opt out status.”

As with DME claims, CMS will implement the PECOS edit for HHAs in two phases. In the first phase that runs from Oct. 4 to Jan. 2, the Medicare claims system will still pay claims without a valid physician National Provider Identifier (NPI) number in the referring physician field, but will give providers an informational message that the claim isn’t valid.

How you’ll know: The remittance advice will include remark code N272 (*missing/incomplete/invalid other payer attending provider identifier*) for claims without a valid NPI. To be valid, the NPI must be in the PECOS system.

And you'd better pay attention to those remark codes. "Agencies will need to start now ensuring that all physicians they receive a referral from are in the PECOS system," says reimbursement expert **Melinda Gaboury** with **Healthcare Provider Solutions** in Nashville, Tenn.

If you ignore those informational edits because the claims still pay, you could hit a big cash drop-off in phase 2. In that phase, which starts Jan. 3, 2011, the claims system will reject claims without a valid NPI in the attending physician field.

Remember: Only physicians enrolled in Medicare can order HHA services, CMS says in the transmittal. And the ordering physician must be a doctor of medicine or osteopathy or have a podiatric medicine specialty.

The good news is that HHAs should have plenty of time to confirm PECOS status of their referring physicians before phase 2 hits, predicts **Lynn Olson** with **Astrid Medical Services** in Corpus Christi, Texas. "With the 60-day episode, the phase 1 90-day period allows the provider to cycle all their ongoing and new patients' physicians," Olson tells **Eli**.

Add a step: Providers check Medicare eligibility for patients before billing, Olson observes. "Now they'll need to check the physician too."

Start Your PECOS Campaign Now

Judging from suppliers' experience so far, HHAs may have an uphill battle getting some of their referring physicians to enroll in PECOS. That's at least partly because the docs' Medicare reimbursement isn't at all affected by the enrollment.

"I don't have control over my physicians," **Carey Jinright** of **Precision Medical Systems** in Montgomery, Ala. told CMS in a Jan. 20 home health Open Door Forum. Physician office managers who are already overwhelmed with other reimbursement concerns and regulatory burdens aren't interested in signing up for PECOS when it doesn't affect their Medicare billing, Jinright said in the forum.

Tip: To avoid triggering the PECOS edit in error, be sure you know how to fill in your referring physician's name on the claim. The edit makes matches to the PECOS list by using the physician's first letter of her first name, first four letters of her last name, and NPI. That means you can't use a nickname like "Bob" when the doc's PECOS file is under "Robert."

(For more tips to avoid PECOS edit rejections, including using CMS's physician file database to check which of your docs are enrolled in the system, see Eli's HCW, Vol. XIX, No. 5, p. 36.)

Regulations

Face-To-Face Encounters Affect Both HHAs And Hospices

And HHAs may be on the hook retroactively.

If you were breathing a sigh of relief that your home health agency wouldn't have to worry about face-to-face encounters after CMS's announcement in the last Open Door Forum that they didn't apply to agencies, suck that breath back in.

The health care reform legislation signed into law in March actually requires face-to-face encounters for both HHAs and hospices, as well as durable medical equipment. The law suggests that the encounter must occur in the six months before certification for HHA services, but leaves it up to the **Department of Health and Human Services** to establish a "reasonable timeframe."

What's more, the Patient Protection and Affordable Care Act (PPACA) makes the requirement retroactive to Jan. 1 for HHAs, says **Mary St. Pierre** with the **National Association for Home Care & Hospice**. "We are writing to CMS about having the date delayed until rule, comments, final rule, and guidance are issued," St. Pierre tells **Eli**.

The law says the hospice requirement will take effect Jan. 1, 2011, St. Pierre notes. CMS says it will issue its regulations about that in the home health prospective payment system proposed rule this year (*see Eli's HCW, Vol. XIX, No. 16, p. 124*).

Centers for Medicare & Medicaid Services staff mentioned the hospice provision in the forum because that provision requires HHS to define attestation procedures, a CMS spokesperson tells **Eli**. "Staff wanted to inform the hospice industry to look for and comment on the proposed hospice face-to-face encounter attestation procedures in the CY 2011 home health proposed rule," the source notes. ❖

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No more substitutions: HHAs hoping to avoid these edits by continuing to use their own NPI in the attending physician field are out of luck. That tactic, which CMS allowed in 2008 because many physicians hadn't yet obtained or communicated their NPIs, will "no longer be valid" when the PECOS edits begin in October, CMS says in a related *MLN Matters* article.

Bright side: At least the implementation date for the HHA edits has been pushed back from the July 2010 date set forth in the health care reform law. And HHAs may benefit from suppliers' efforts in this area over the last six months or so. ❖

*Note: The transmittal is at www.cms.gov/transmittals/downloads/R677OTN.pdf and the *MLN Matters* article is at www.cms.gov/MLNMattersArticles/downloads/MM6856.pdf.*



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Eli's Home Care Week™ (USPS 021-972 ISSN 1548-8829 [print] ; ISSN 1948-1063 [online]) is published weekly, except the publishing dates the weeks of the following holidays: New Year's Day, Easter, Memorial Day, 4th of July, Labor Day, Thanksgiving, and Christmas, by Eli Research, 2222 Sedwick Rd. Durham, NC 27713.

Application to mail at periodical rates is paid at Durham, NC 27705 and at additional mailing offices. Subscription price is \$297. Subscriptions are also available in e-mail PDF format. Bulk pricing available.

Labor Law

Labor Law Changes Could Bring Trouble

DOL may revise companionship exemption, endorses penalties for misclassifying contractors.

Federal changes for your home health agency or hospice aren't just coming from Medicare — the **Department of Labor** could soon make a big difference in your operations.

That's because the DOL's Wage and Hour Division is considering revising the definition of the companionship exemption, which exempts companion aides from Fair Labor and Standards Act requirements for minimum wage and overtime pay. The DOL plans to issue a proposed rule on the matter in October 2011, it says in its regulatory agenda published in the April 26 *Federal Register*.

"DOL intends to consider whether the scope of the companionship exemption as currently defined in the regulations continues to be appropriate in light of substantial changes in the home care industry over the last 35 years," the agency says in a fact sheet about the initiative.

For one, the DOL wants to look at whether the exemptions should apply to aides employed by third parties (i.e., home health agencies). And the agency wants to take another look at the definition of "untrained" which allows aides to qualify for the exemption.

If the DOL tightens up the training requirement, "it would not take a very high standard to make every companion, home health aide, attendant, etc. of a licensed/certified provider non-exempt," warns attorney **Robert Markette Jr.** with **Gilliland & Markette** in Indianapolis.

The DOL also will examine the amount of household work an aide is allowed to perform and still qualify for the exemption, the fact sheet says.

"The companionship services exemption has been a protracted, hotly contested issue," notes the **National Association for Home Care & Hospice**. Union organizers have made it a goal to eliminate the exemption for HHA workers.

The result: If the DOL does revise the exemption to exclude HHA employees, workers and patients will be the ones who suffer, Markette maintains. That's because agencies will restrict aide hours and divvy up assignments between more aides in order to reduce overtime exposure.

Or HHAs will pass on higher costs to patients, who will opt to hire aides for fewer hours, Markette predicts.

“Merely increasing costs for the provision of home care services without also addressing the funding for that care would only serve to harm the home care aides and the people under their care,” NAHC says.

The DOL also might plan to crack down on misclassification of directly employed workers as contract staff. In an April 22 release, Labor Secretary **Hilda Solis** lauded two pieces of newly proposed legislation that would increase penalties for misclassifying employees as contract when they are direct.

“One of my goals as secretary of labor is to secure minimum and overtime wages and to help middle class families remain in the middle class,” Solis says in the release. “Working on the issue of misclassification is key to attaining those goals because misclassification of employees as independent contractors deprives employees of critical workplace protections and employment benefits to which they are legally entitled.” ❖

Note: The companionship exemption fact sheet is online at www.dol.gov/regulations/fact_sheets/whd-fs-flsa-companionship.htm.

Industry Notes

Get To Know New Outlier Cap Remittance Advice Codes

Goodbye CARC 45, hello CARC B5.

If you're trying to figure out whether your claims have been adjusted due to the outlier cap, you can check for a new RARC/CARC code combo.

When the system makes an adjustment based on the cap, it will use remittance advice reason code N523 (*The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid*) and the newly associated claim adjustment reason code B5 (*Coverage/program guidelines were not met or were exceeded*), the **Centers for Medicare & Medicaid Services** explains in April 28 Transmittal No. 1956 (CR 6897).

Before March 1, CMS used CARC 45. “The combination of CARC B5 and RARC N523 describes the outlier limitation more accurately,”

notes the transmittal at www.cms.gov/transmittals/downloads/R1956CP.pdf.

- **The home care and therapy industries got a black eye** from a *Wall Street Journal* investigation of Medicare reimbursement for home health agencies. In an April 26 article, the *Journal* suggests that HHAs are taking advantage of Medicare reimbursement by changing therapy visits in accordance with Medicare payment incentives. The article pointed a finger at publicly traded companies like **Amedisys Inc.**

- **Medicare contractors will need to have a little better proof** when they revoke your billing privileges after a site visit shows you aren't operating at the location stated on your enrollment form.

Among other things, contractors should document your operation being closed with date- and time-stamped photographs, says April 23 Transmittal No. 334 (CR 6895). The individual that performed the site verification visit must also sign a declaration, the transmittal adds.

Some providers have reported that their Medicare contractor has lost or just not processed their 855A form changing their practice location, NAHC says. If that's the case and your billing privileges are yanked after a site visit, you can file a corrective action plan within 30 days to show you were in compliance, the trade group advises.

Tip: To avoid problems, retain a copy of all 855A filings you submit and follow up with the contractor if you don't receive verification of the change you've filed, NAHC counsels.

The transmittal is online at www.cms.gov/transmittals/downloads/R334PI.pdf.

- **Get ready for more than 130 new ICD-9 diagnosis codes** debuting on Oct. 1. CMS has proposed the full listing of codes in a 1,000+ page *Federal Register* file. More than one-third of the proposed codes are in the “V” code section, which describes “supplementary classification of factors influencing health status and contact with health services,” according to the ICD-9 manual.

For a breakdown of how the new codes will influence home care coding, see a future issue of *Eli's Home Care Week*.

- **Hospice patients who revoke the hospice benefit don't have to wait** any prescribed amount

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of time before re-electing it, regional home health intermediary **Cahaba GBA** says in its May newsletter to providers.

“Upon revoking the election of Medicare coverage of hospice care for a particular election period, an individual resumes Medicare coverage of the benefits waived when hospice care was elected,” CMS says in the *Medicare Benefit Policy Manual*. “An individual may at any time elect to receive hospice coverage.”

“Therefore, if the patient/family revokes the hospice benefit, they can re-elect at any time, as long as it is not the same day as the revocation,” Cahaba explains in the newsletter. Of course, the patient must also meet the hospice coverage criteria.

• **If you need more ammo to convince law-and policymakers** that funding home care makes good budget sense, check out insurance company **Genworth’s** latest survey on long-term care costs.

The cost of licensed homemaker services grew just 2.7 percent in 2010 compared to 2009, and the cost of licensed home health aides grew 3 percent, says the *Genworth 2010 Cost of Care Survey*. That compares to a 12 percent increase for assisted living facilities and adult day health care. The cost of nursing home care grew more than 5 percent in the time period, says the study online at www.genworth.com/costofcare2010.

• **You can stop worrying** about coming up with a list of approved abbreviations, symbols, and dose designations if you’re accredited by **The Joint Commission**.

When the accrediting body formerly known as JCAHO revised its National Patient Safety Goal on abbreviations this year, “organizations were confused by the new language,” the Commission says on its website. They thought the new language “seemed to imply that organizations had to create lists of approved abbreviations, acronyms, symbols, and dose designations.”

But “this was not the intention of the revision,” stresses the Oakbrook Terrace, Ill.-based Commission. The language will revert back to its 2009 version starting July 1.

• **LHC Group Inc. saw positive earnings** in the latest quarter. The Lafayette, La.-based chain reported revenues of \$145.9 million for the quarter ended March 31 compared to \$124.5 million in the

year-ago quarter. Net income rose modestly from \$15.1 million to \$15.8 million during that time period, LHC says.

LHC’s patient outcome scores rose in all 12 publicly reported outcomes on Home Health Compare, it says in a release. CEO **Keith Myers** also predicted “more certainty in regards to the long term reimbursement environment,” thanks to enactment of the health care reform law. That stability will fuel industry consolidation, he expected.

• **For-profit hospice chain Odyssey Inc.’s earnings** are on the upswing.

The Dallas-based national chain’s admission volume helped reduce the company’s Medicare cap adjustment, said CEO **Robert Lefton** in a release. Odyssey also reduced its claims subject to additional development requests (ADRs), he said.

Odyssey reported net income of \$13.7 million on revenues of \$171.5 million for the quarter ended March 31. That’s compared to an \$8.9 million profit on revenues of \$167.5 million for the same time period in 2009. ❖

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