

Eli's Hospice Insider

Your guide to compliance, payment, and successful hospice operations.

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HOSPICE VISITS

Here's the Latest on How to Count Your Inpatient Hospice Visits

► **CMS' new guidance gives you the low-down on what counts as a visit in hospice facilities.**

Are your claims getting kicked out of the Medicare system for having too many line items? If so, chances are you aren't reporting your inpatient visits correctly.

The problem: The Centers for Medicare & Medicaid Services (CMS) requires hospices to report visits by their nurses, home health aides, social workers, physicians, and nurse practitioners. When the patient is residing in a hospice facility, the definition of what constitutes a visit seems to be confusing hospices, said CMS's **Randy Thronset** in last month's Open Door Forum for home care providers.

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RAC DENIALS

Arm Yourself with 6 Rules for Battling Unfair RAC Denials

► **When things look darkest, a new viewpoint can make all the difference in your appeal.**

Recovery Audit Contractors (RAC) have already begun multiple durable medical equipment audits. Hospices could be next on their hit list.

To get ready for RAC denials and your appeals, check out these potential pitfalls and tips for winning.

Rule No. 1: Know who you are up against. "RACs aren't likely to deny anything where they don't believe they have ... a 90 percent chance of recovering money," says **Pauline Franko** of Encompass Consulting & Education in Tamarac, Fla.

And, "you can figure the RAC is going to fight tooth and nail to make sure a denied claim stays denied upon appeal," says **Victor Kintz** with Polaris

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Hospice Visits, continued from cover

“Providers are finding it difficult to correctly count visits for patients that are in a facility,” agrees billing expert **M. Aaron Little** with BKD in Springfield, Mo. In an inpatient hospice facility, “there are many times when there is an encounter with the patient.”

The solution: Hospices should look to CMS’s hospice visit reporting basics to avoid over-reporting of visits, Thronset said. Hospices should only report visits that are reasonable and necessary for the palliation and management of the terminal illness.

“Hospices shouldn’t record a visit for every time a staff member enters the patient’s room,” Thronset instructed. Instead, they should consider whether the visit would have been reported if the patient were receiving routine home care in her private home. If a group of tasks is usually performed in a single visit in a patient’s private home, the hospice should count the tasks as a single visit for a patient residing in a facility, he advised.

For example: If an aide enters the room, is interrupted and steps out, then re-enters the room, that shouldn’t count as two visits, Thronset explained. Ditto for a nurse who has to leave the room to get medication. “Use your clinical judgment,” he exhorted.

“Based on CMS’s guidance, not every single encounter would constitute a billable visit,” Little counsels.

“Ultimately the decision of whether to count an encounter as a visit lies in exercising effective clinical judgment.”

Tip: Adhere as closely as possible to CMS’s guidance on counting hospice visits that it has issued in program manuals and question-and-answer sets, Little recommends.

Q&As 8900 and 8915, which address counting visits in facilities, might help shed light on the matter. To see all the Q&As about hospice, including multiple items on how to count visits, go to <https://questions.cms.hhs.gov>, choose “Medicare” in the “Search by Product” box, then choose “Medicare Fee-For-Service Payment” in the next box, then choose “Hospice” in the last box, and hit the “Search” button. You can also consult CMS’s April 2008 transmittal setting out the visit counting rules at www.cms.gov/transmittals/downloads/R1494CP.pdf.

Patients in Facilities May Need More Visits

CMS is telling hospices to compare inpatient visits with private home ones, but don’t expect to see the same amount of visits in both locations, cautions **Samira Beckwith**, president and CEO of Hope Hospice and Community Services in Fort Myers, Fla.

“If someone resides in a facility, it most likely means that they need

more help than if they were at home,” Beckwith points out. “I would not be surprised to see more visits.”

But CMS thinks if hospices follow their new guidance, visit numbers will be significantly cut. “A lot of those instances where the number of line items [on claims] is exceeding those that are allowed is because every time that that staff person goes in and out of there, it’s being recorded as a separate visit,” Thronset told a caller in the forum. “Or they’re simply recording the multiple paths that would make up a visit as separate visits.”

“We believe that if they follow the guidance ... they won’t be exceeding the number,” he added.

Concern: CMS may be helping hospices nail down the details of how to count visits, but the new guidance doesn’t address a major concern Beckwith has: focusing too much on the medical component of the Medicare hospice benefit. “Hospice developed because of the needs that exist during this very difficult and important chapter of a person’s life,” Beckwith notes. “Now CMS and others want to go backwards and medicalize hospice.”

Visit reporting, which doesn’t include visits from pastoral care and other services, also “doesn’t allow for an accurate representation of the total care needs,” Beckwith worries. ■

RAC Denials, continued from cover

Group based in Tampa, Fla. That’s because “the outcome will affect whether or not they will be paid for the work done on that claim.”

Rule No. 2: If you think you’re right, however, fight. Providers should decide whether to appeal on a case-

by-case basis, says Kintz. But speaking generally, Kintz notes that if a provider delivered a covered service and documented it — “and the RAC or another post-payment audit group says [the provider] billed Medicare incorrectly” — he would not want to admit that by not appealing.

Good point: “If you don’t appeal, you have been put on notice that you did something deemed to be wrong,” observes attorney **Amy Fehn** with Wachler & Associates in Royal Oak, Mich. And “if you don’t fight it, you should arguably change your practice

Compliance, continued on page 27

APPEALS

Don't Let RACs Shoot Down Your Whole Claim For A Small Error

► Wheelchair appeal targets unfair recoupment amount.

Some providers aren't taking what they view as unfair Recovery Audit Contractors (RAC) denials lying down. Keep an eye on their actions to learn what you may be up against when the RACs begin targeting hospice claims.

Case in point: A durable medical equipment company is appealing a RAC recoupment involving what the RAC claims to be noncompliant billing for a power wheelchair. The billing allegedly violated some bundling rules that are part of a local coverage decision, reports attorney **Amy Fehn**, whose law firm is handling the appeal for the DME provider.

"The issue involves armrests," adds Fehn, where the local coverage determination (LCD) policy "has a chart saying if you are providing this code and this code, they should be bundled with a certain other code." The guidance, however, on the bundling issue isn't very clear, she adds.

And, "even if there is an error, it may be a \$20 error whereas the RAC is trying to disapprove thousands of dollars by denying the whole claim," says Fehn, with Wachler & Associates in Royal Oak, Mich.

Another example: In Florida, "providers have had Part B rehab

therapy claims denied because claims had two untimed codes appearing on the same claim," says **Nancy Beckley** with Bloomingdale Consulting Group Inc. in Brandon, Fla.

The problem: "There is no prohibition against billing two untimed codes — the approved [RAC] issue is for two units of an untimed code," says Beckley. And, "Florida providers are appealing that issue because it represents a misinterpretation of untimed codes by the RACs. An example would be a speech swallowing evaluation and a speech swallowing service on the same claim." ■

RAC Denials, continued from page 26

patterns." (Fehn notes, however, that it isn't necessarily an admission of wrongdoing if you don't appeal.)

Rule No. 3: Beware blanket appeal tactics. Appealing every RAC denial in an effort to "clog up the system" can backfire, cautions Tim Johnson, executive director of Castle Rock Medical Group in Denver. That approach can put the provider in the position of facing "potential fraud allegations" by maintaining that everything they are doing is OK and continuing their current practices. "You want to change your operations to adhere to [Centers for Medicare & Medicaid Services] payment criteria," he stresses.

Rule No. 4: Don't count yourself out due to lack of solid documentation. You can summarize services provided but not documented in a late entry and/or put the information in a cover letter, advises Franko. Also,

"look at other ways to validate that you provided a service that wasn't documented properly." For example, a SNF could show that the patient signed into the therapy gym for services, she notes.

Rule No. 5: Before you cry '*mea culpa*,' consider other ways to prevail. Even if you are completely wrong on an issue, take a closer look to see if you can get off the hook. "We advise looking at every angle before a provider throws in the towel and pays the money back," says Fehn. For example, "did the RAC go back too far?" she asks.

Perhaps the RAC could reopen the claim, "but did they have good cause to revise it?" Fehn asks. She also points to "waiver of liability and provider without fault arguments," where you examine the guidance that the provider had from CMS on the issue at the time. "The guidance may be clear now to show that the provider did something wrong, but it might not have

been so clear at the time" the provider rendered the services, she points out.

One key example of a change in guidance involves the inpatient rehab facility rules, says Johnson. "From 1985 through the end of last year (Dec. 31, 2009), the *Medicare Benefit Policy Manual*, chapter 1, section 110 includes regs driven by the Health Care Financing Administration (HCFA) 85-2 ruling, which was rescinded ... effective the end of last year. Starting Jan. 1 of this year, an entire new set of regs [replaced] chapter 1, section 110."

Rule No. 6. Take your appeal to the administrative law judge, if needed. "We have the greatest success at the administrative law judge level," notes Fehn. "So to just say you are going to appeal to the reconsideration level means you are missing your best opportunity" at prevailing upon appeal, she says.

Kintz agrees that "getting in front of a human to plead your case is where a lot of denials get overturned." ■

CLIP AND SAVE

Keep this Chart Handy to Master New Claim Requirements

► *Welcome this ambulance transport responsibility clarification.*

If you're feeling confused about the many new requirements the Centers for Medicare & Medicaid Services have unveiled for 2010, you're not alone. **M. Aaron Little, CPA**, senior managing consultant with BKD in Springfield, MO offers this rundown to help keep your claims in order.

Change Request	Effective for	Requires	Applies
6440	Service dates on or after Jan. 1	<ul style="list-style-type: none"> • Line item billing of visits for all service disciplines in 15-minute increments • Billing of therapy services • Visit reporting for phone calls made by medical social services when calls are related to providing or coordinating care for the patient or providing counseling to the patient's family. Calls must be described in the plan of care and documented in the clinical record. 	<ul style="list-style-type: none"> • To visits provided by hospice employees to patients receiving routine home care, continuous home care, or respite care • Does not apply to visits provided by non-hospice employees to patients residing in contracted facilities when the patient is receiving respite care or general inpatient care.
6540	Service dates on or after April 1	Reporting of two physicians on all notices of election & claims: Attending physician and Other physician (responsible for certifying that the patient is terminally ill)	Even if the attending and other physician are the same individual, in which case you would list the same physician in both claim fields.
6791	Claims received on or after April 29	Line item reporting of hospice levels of care. Report new claim service dates and lines each time a level of care changes.	To routine home care, respite care, and general inpatient care only.
6778	Claims submitted after July 6	<ul style="list-style-type: none"> • Payment of Medicare-covered services provided on the date of a hospice election when the patient has a Medicare Advantage plan. • Clarifies that hospices are not responsible for ambulance transports that occur on the date of hospice election but before all criteria for hospice eligibility and coverage are met. • Implements claims edits to ensure that the appropriate place of service is reported for general inpatient care (Medicare-certified inpatient hospice facilities, hospitals, or skilled nursing facilities), respite care (Medicare-certified inpatient hospice facilities, hospitals, or skilled nursing facilities), and continuous home care (patient's home). 	

Visit the CMS Web site to get all the details for these new claims requirements.

For change request 6440: www.cms.hhs.gov/transmittals/downloads/R1738CP.pdf

For change request 6540: www.cms.hhs.gov/transmittals/downloads/R1885CP.pdf

For change request 6791: www.cms.hhs.gov/transmittals/downloads/R1897CP.pdf

For change request 6778: www.cms.hhs.gov/transmittals/downloads/R121BP.pdf and

www.cms.hhs.gov/transmittals/downloads/R1907CP.pdf ■

PROTECT YOUR EMPLOYEES

Protect Your Employees with These 5 Tips

► *These checklists help you keep workers safe and improve retention.*

If you're looking for ways to keep your hospice employees safe and on the job, the **Centers for Disease Control** has a nifty new 51-page resource for you. And we've got some information on how you can improve upon an important point it missed.

Occupational Hazards in Home Healthcare, which is co-written by the **National Institute of Occupational Safety and Health (NIOSH)** identifies the top hazards, as well as good tips.

Don't miss the checklists at the end of the booklet that help workers think about how things as simple as the shoes they wear or talking on the cell phone while driving can impact their safety.

Use These Tips to Address Occupational Hazards

The second step is to develop prevention strategies. Here are some helpful tips for the top five most common hazards:

1. Overexertion: You may wish to consult with a professional who has expertise in patient-care ergonomics. This will help you to determine when assistive devices may be necessary. These professionals should also provide equipment training.

2. Latex Sensitivity: Provide workers with non-latex gloves when there is minimal contact with infectious materials. If the potential exists for contact with infectious materials, select gloves that pass the ASTM F1671 penetration test for resistance to bloodborne pathogens. Many manufacturers have appropriate gloves for infectious materials.

If latex gloves are selected, provide reduced-protein, powder-free gloves and also provide training to supervisors and staff on latex allergy. Arrange a medical evaluation for workers with early symptoms and for those with

allergies and then ensure homes are kept clean, perhaps with a vacuum with a high-efficiency particulate air filter.

3. Bloodborne Pathogens: Make sure to meet all the requirements of the Occupational Safety and Health Administration (OSHA) bloodborne pathogens standard. Eliminate the use of needle devices whenever safe and effective alternatives are available. Provide needle devices with safety features and determine which are most effective and acceptable. Establish an exposure-control plan; evaluate and update annually.

4. Occupational Stress: Provide frequent, quality supervision and staff support along with adequate job training and preparation. Hold regular staff meetings where problems, frustrations and solutions can be discussed. Include lunch breaks and sufficient travel time in workers' schedules.

5. Violence: Develop a standard definition of workplace violence and create a zero tolerance policy. Ask employees to report each incident. Regularly conduct training on workplace violence. Inform workers of assignment risk and teach them how to assess safe work environments and surroundings.

For instance, train staff on how to recognize verbal abuse; and how

to identify different types of illegal drugs and drug paraphernalia. Then, give them the tools needed for safely addressing these problems.

What the Report Misses

The NIOSH may be looking at musculoskeletal injuries through rose-colored glasses, notes attorney **Robert Markette** on his blog. The report recommends that workers use devices to lift patients, as nursing facility workers do. "This is a good point, but the authors seem to have overlooked a key problem," Markette notes. "Home health and facilities are different -- [workers] go into a patient's home and often rely upon the equipment the family has obtained."

One possible work around, Markette suggests, is to consider how your employees are going to transfer the patient during the care planning stage. Perhaps Medicare will foot the bill for some medically necessary equipment.

Resource: Read the full document, and access all tips and checklists for home healthcare workers' safety, at www.cdc.gov/niosh/docs/2010-125/pdfs/2010-125.pdf. ■

Some top dangers, according to the report, include:

- overexertion;
- stress;
- guns and other weapons;
- illegal drugs;
- verbal abuse and other forms of violence in the home or community;
- bloodborne pathogens;
- needlesticks;
- latex sensitivity;
- temperature extremes;
- unhygienic conditions, including lack of water, unclean or hostile animals, and animalwaste; and
- long commutes from worksite to worksite leading to transportation-related risks. ■

EDUCATION

Get the Compliance Answers You Need on Discharges and Transfers, Gift-Giving Guidelines

► *These educational offerings clear up confusion in a matter of minutes.*

Get vital information on these topics from the comfort of your own office:

• **Revocations, Discharges and Transfers — Handle with Care.**

Tuesday, May 11, 1:00 pm ET. With hospice live discharge questions abound: What exactly is the difference between a revocation and a discharge? Under what circumstances can the hospice initiate discharge? What kind of notice must be given and what is the time frame? Is an order required? **Susan Balfour, BA,**

RN sorts it all out. Join Susan for this 1-hour seminar where she clarifies what actions are needed in specific situations.

For more information, go to www.audioeducator.com/conference-Revocations-Discharges-and-Transfers-Handle-with-Care-051110 or call 1-800-508-2582.

• **Gifts and Discounts: What's Permissible, What's Not.** **Thursday, May 27, 1:00 pm ET.** Recent OIG settlements indicate that the government may come down hard

on non-compliant gift giving that bestows even small value to referring parties. Courtesies like gifts or discounts may express appreciation, but can also implicate federal and state laws pertaining to kickbacks and self-referral prohibitions. Join nationally known healthcare attorney **Wayne J. Miller, Esq.,** for this 90-minute seminar.

For more information, go to www.audioeducator.com/conference-gift-discount-policies-documentation-270510 or call 1-800-508-2582. ■

LEGISLATION

Hospice Face-To-Face Requirement Tucked into Home Health PPS

► *Hospices are in for more medical review under health care reform package.*

The new health care reform package includes a lot of new requirements and the result can sometimes be confusion.

For example: The Centers for Medicare & Medicaid Services (CMS) will be issuing in the upcoming home health agency prospective payment system proposed rule a new requirement that a physician see a patient face to face before certifying her. However, even though it's in the HHA rule, the requirement will apply to hospice patients only, CMS clarified in the April 14 Open Door Forum for home care providers.

That is a big relief for HHAs that thought the face-to-face requirement in the Patient Protection and Affordable Care Act (PPACA) would apply to them. But it still places a heavy regulatory burden on hospices.

Under PPACA, for services on and after Jan. 1, 2011, a physician or nurse practitioner must have a face-to-face encounter with hospice patients to determine their continued eligibility, CMS's Randy Thronset explained. The requirement applies to recertifications at 180 days and each subsequent recert.

That physician or NP also must attest that such a visit took place, Thronset added.

Plus: Hospices with a large ratio of long-stay patients will have their care medically reviewed, the legislation adds.

This hospice provision will most likely go into the HHA proposed rule because there isn't time for a hospice payment proposed rule before 2011

rates must take effect in October, Thronset explained.

Watch out: Home care providers can expect to see information about more PPACA-related provisions coming out. "There were a number of provisions in the [PPACA legislation] that affected home care and hospice," Thronset noted. "We are currently analyzing many of these provisions to determine the specifics with regards to how the provisions will ultimately be implemented."

In many cases, CMS will issue a proposed rule for new requirements. That means HHAs can expect the 2011 PPS proposed rule to be a doozy this year, observers predict. Right now CMS is predicting to issue that rule in August, but that date is subject to change. ■

INDUSTRY NEWS

• **Don't forget about two new hospice billing requirements** that take effect this month.

Number 1: For hospice claims and notices of election with dates of service on or after April 1, you must include the attending physician's information in the ATT PHYS (FL 76) field and the certifying physician's info in the OTH PHYS (FL 79) field, regional home health intermediary Cahaba GBA explains on its Web site.

Number 2: For claims submitted on or after April 29, you must report a separate level of care revenue code line each time the level of care changes, Cahaba says.

More details and resources are at www.cahabagba.com/rhhi/news/20100409_hospice.htm. Also, see our related chart on page 28.

• Get ready for a shorter deadline to submit Medicare claims. Providers now have one calendar year after the date of service to file a claim with Medicare, CMS notes. The change was included in the recently enacted health care reform legislation, the Patient Protection and Affordable Care Act (PPACA), with the aim of reducing fraud, abuse, and waste.

The deadline applies to services and items furnished Jan. 1, 2010 and later. From Oct. 1 to Dec. 31 of 2009, providers have until Dec. 31, 2010 to file claims.

Stay tuned: CMS may establish exceptions to the one-year filing deadline in future rulemaking, the agency says.

• In your eagerness to appeal a denied claim, don't forget the first step. Qualified Independent Contractor First Coast Service Options says it is dismissing many second-level reconsideration appeals because the provider hasn't received a first-step redetermination notice from its Medicare contractor.

Some providers are confused over the appeals process steps, First Coast says in the National Government

Services (NGS) April newsletter for providers. But others are mixing up written or phone inquiry responses from Medicare Administrative Contractors (MAC) with official redetermination notices.

Tip: The official Medicare Redetermination Notice (MRN) should include the date of the original decision, a clear statement of the "favorable, partially favorable, unfavorable, or dismissed" decision, and information on further appeal rights including the Qualified Independent Contractor (QIC) address.

Providers have 120 days from receiving the remittance advice to request a redetermination notice, First Coast notes in the newsletter. "You do not get extra days if you send it to the wrong entity," the QIC emphasizes.

• Don't stress over trying to get a verbal hospice certification narrative within two days of the start of care. So says a recent Frequently Asked Question from CMS.

When obtaining verbal certification or recertification, you don't have to secure a verbal narrative justifying the six-month prognosis at the same time, regional home health intermediary Cahaba GBA notes on its Web site. "While a verbal narrative is not required as part of the oral certification/recertification, the written narrative is required prior to filing a claim," CMS says in FAQ 9969.

Also, remember that "the essence of what the written narrative will ultimately entail in its explanation of the clinical findings that support a life expectancy of six months or less, is expected to be the basis for the oral certification/recertification," CMS adds.

• Advance directives appear to be working to get people the care they prefer at the end of life. So says a new study in the April 1 *New England Journal of Medicine*.

In a study of cases from 2000 to 2006, patients who had living wills

requested comfort care in 96 percent of cases. Of 3,746 subjects, 70 percent of those who required decision-making about end-of-life issues weren't capable of making the decisions at that time, notes the study by University of Michigan and Veterans Affairs researchers.

"Patients who had prepared advance directives received care that was strongly associated with their preferences," says the study's abstract. "These findings support the continued use of advance directives."

• Finding what you need on the CMS Web site may now be a few characters easier.

The agency has shortened its Web address from the former www.cms.hhs.gov to just www.cms.gov. "Existing bookmarks and links from other Web sites will continue to work following this address change," the agency pledged before the April 2 transition.

• If you've had your claims returned with reason code 32024 recently, you may need to F9 them to get your rightful payment.

The code, which says "The admission date on the claim is greater than the provider's cancel (termination) date on the provider file," was applied in error to claims when the provider had no billing activity in the past 12 months, regional home health intermediary Palmetto GBA reports on its Web site.

"Providers should go to their claims in TB9997," Palmetto instructs. "F9 the claims that are receiving reason code 32024 in order to move the claim back through the system."

• Hospice Q&As. CMS has updated several hospice questions-and-answers on its Web site and added a new one, CMS's **Katie Lucas** said.

For example: The agency updated questions about hospice visit charges and counting visits in a facility, and added a new Q&A about counting visits as well.

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INDUSTRY NOTES (Cont.)

You can get the Q&As by going to CMS's hospice page at www.cms.gov/center/hospice.asp, scrolling down to the "How To Stay Informed" section in the right column, and clicking on the "Questions and Answers: Hospice" link.

- If you've got questions about the recovery audit contractors (RACs), a new series of free conference calls from CMS may give you answers. The agency has scheduled four 90-minute calls for May 4, May 5, and May 12.

"These calls offer another opportunity for providers who missed the earlier presentations to hear the RAC 101 session and to ask any questions they may have regarding the RAC process," CMS says.

You need not register for the calls, but to get the dial-in information, visit the CMS Web site at www.cms.gov/RAC/03_RecentUpdates.asp.

In the meantime, you can find out how Medicare is improving its processes so that providers can track RAC recoupments in a new *MLN Matters* article. CMS "is not providing enough detail currently in the Remittance Advice (RA) to enable providers to track and update their records to reconcile Medicare payments," the agency admits in the article.

The new remittance advice information which will enable better tracking is in the article at www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf. The changes will take effect in July.

- Don't forget to take a moment next month to recognize your nursing staff's efforts.

National Nurses Week is May 6-12, accrediting body The Joint Commission reminds providers. "National Nurses Week provides a special opportunity to thank the more than two million nurses throughout the United States who positively influence the lives they touch," says the Commission's **Ann Scott Blouin, Ph.D., R.N.** "As nurses, we work in many different settings and serve in many roles, but all of us share a single focus on keeping patients safe by providing quality care."

Ideas for celebrating National Nurses Week are at the American Nurses Association's Web site at <http://nursingworld.org/NationalNursesWeek>. ■

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