

Home Health Line

Regulatory news, benchmarks and best practices
to build profitable home care agencies

homehealthline.com

IN THIS ISSUE

October 3, 2016 | Vol. 41, Issue 38

Investigate translation service options,
prepare for proposed patient rights CoP1

Illinois' pre-claim reviews are proving
burdensome for home health agencies1

Get ready to work with house calls
physicians in caring for the chronically ill2

2017 guidelines: Hypertension, heart
disease can now be assumed to be connected.....3

Supervisory visits ensure agencies
maintain quality, standards4

Wait before getting your patient rights
forms translated into various languages5

Benchmark of the Week

What patient rights changes has your agency
made to comply with the proposed CoPs?6

Proposed CoP Prep

Investigate translation service options, prepare for proposed patient rights CoP

Select a translation service if your agency hasn't done so already. Such a service will help your agency better communicate patients' rights and other information to patients and their caregivers in the event your clinicians don't speak the same language as your patients.

That's one step your agency should take even before the revised Conditions of Participation (CoPs) are finalized. Industry experts speculate the CoPs will be released in the fall, or at least by year's end.

(see **CoPs**, p. 5)

Regulatory compliance

Illinois' pre-claim reviews are proving burdensome for home health agencies

Want evidence CMS' pre-claim review demonstration, in the name of fighting fraud, is penalizing honest home health agencies and panicking seniors? Consider what has happened in Illinois since pre-claim reviews began there Aug. 3, according to the Illinois HomeCare & Hospice Council:

- **Medicare Administrative Contractors (MACs) have refused to affirm 60% to 80% of home health claims** Illinois agencies have submitted in advance of actual

(see **Reviews**, p. 7)

Attend the Claims Management Conference



During this two-day conference, you'll learn key strategies to refine your claims processes and ensure accurate and timely payments. The conference will be held Dec. 8-9 in Las Vegas. Register at <http://decisionhealth.com/claimsmanagement/register.html>.

*Regulatory compliance***Get ready to work with house calls physicians in caring for the chronically ill**

Medicare savings achieved so far by the Independence at Home demonstration have attracted Congressional support for legislation to use house calls teams to treat chronically ill seniors a permanent Medicare benefit.

The demonstration's second year of savings — announced Aug. 9 — has increased chances that Congress will make house calls a standard Medicare benefit for up to 2 million chronically ill Medicare beneficiaries nationwide, believes Gary Swartz, associate executive director of the American Academy of Home Care Medicine.

The Independence at Home program focuses on avoiding ER visits and hospitalizations for the 5% of beneficiaries with multiple chronic conditions and disability who account for nearly 50% of Medicare spending. That means a nationwide program could generate Medicare savings and practice incentive payments of up to \$34 billion over 10 years, according to a recent study, Swartz says.

It also could be an opportunity for home health agencies to serve as partners of house calls groups, he adds. For instance, one of the existing house calls groups involved in the demo contracted with agencies to augment its physician and nurse practitioner team.

The aim of the demo, which began in 2012 is to show whether home-based care can reduce hospitalizations and improve patient and caregiver satisfaction while lowering Medicare costs of care for the 10,484 mostly chronically ill beneficiaries enrolled by the 15 participating house calls practices. Reductions in hospitalizations, rehospitalizations and ER visits by practice but in some cases have been almost 50%.

A national house calls benefit by 2017?

Despite the gridlock on Capitol Hill, Congress last year cleared bipartisan legislation extending the Independence at home demo for two additional years through fiscal 2017.

Currently pending is a bipartisan Senate bill (S. 3130) that would establish house calls as a standard Medicare benefit. Given the unanimous support for the Independence at Home demo's two-year extension, chances are good for approval of the Senate bill by both houses next year, Swartz believes.

Among the 15 participating house calls groups, the Virginia Commonwealth University (VCU) Health Systems Group is the only one that has contracts with freestanding home health agencies. Several other house calls groups make use of agencies affiliated with their system's hospital.

As CMS reported, the 15 practices combined saved Medicare over \$10 million in the demo's second performance years ended in May and August 2014, or an average \$1,010 per participating beneficiary. Only seven of the practices, including VCU's, achieved enough

Subscriber Information ▶ Have questions on a story? Call or email us.**EDITORIAL**

Have questions on a story? Call or email:

President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice President:
Corinne Kuypers-Denlinger
1-301-287-2363
ckuypers-denlinger@decisionhealth.com

Senior Content Manager:
Marci Heydt, 1-301-287-2299
mheydt@decisionhealth.com

Director of Product Management:
Maria Tsigas, 1-301-287-2305
mtsigas@decisionhealth.com

Senior Editor: Burt Schorr
1-240-497-0392
burt.schorr@verizon.net

Lead Editor: Josh Poltilove
1-301-287-2593
jpoltilove@decisionhealth.com

**PLEDGE OF INDEPENDENCE**

At DecisionHealth, the only person we work for is you, the provider. *Home Health Line* is not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the healthcare industry. For nearly three decades, we've been independently watching out for the financial health of healthcare providers, and we'll be there for you and your peers for decades to come.

WEBSITE

www.homehealthline.com

SUBSCRIPTIONS

Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email customer@decisionhealth.com.

ADVERTISING

To inquire about advertising in *HHL*, call Elizabeth Christian, 1-301-287-2232.

COPYRIGHT WARNING

Copyright violations will be prosecuted. *Home Health Line* shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal photocopying or electronic redistribution. To report violations, contact our copyright attorney Steve McVeary at 1-301-287-2266 or email smveary@ucg.com.

REPRINTS

To request permission to make photocopy reprints of *Home Health Line* articles, call 1-855-CALL-DH1 or email customer service at customer@decisionhealth.com. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number.

Home Health Line is a registered trademark of DecisionHealth. DecisionHealth is a registered trademark of UCG. *Home Health Line* is published 48 times/year by DecisionHealth, 9737 Washingtonian Blvd., Ste. 502, Gaithersburg, MD 20878. ISSN 0893-8121. Price: \$597/year. © 2016 UCG DecisionHealth

savings to qualify for a practice incentive payment, though all 15 practices showed improvement based on at least two of the six quality measures, CMS says.

The measures include “follow-up contact within 48 hours of hospital admission, hospital discharge and emergency department visit,” “all-cause hospital readmissions within 30 days,” and “medication reconciliation in the home within 48 hours of hospital discharge.”

The second-year savings were below the more than \$25 million saved in the demo’s first performance year, which ended in mid-2013, a difference that reflected a change by CMS in the way it compared costs of enrolled beneficiaries with costs of a same-sized control group with matching characteristics whose members received standard Medicare coverage.

VCU participates in the demonstration as one of three house calls groups comprising the Mid-Atlantic Consortium. Because the consortium achieved nearly \$500 per patient in Medicare savings, as calculated by CMS, it’s in line for a practice incentive payment of nearly \$867,000.

Demo generates referrals for agency

Advance Care is one of three Richmond, Va., Medicare home health agencies VCU has contracted with to aid its physician and nurse practitioner team.

VCU chose the agencies based on a variety of criteria including whether they have enough clinicians to fill a same-day visit request when the patient’s condition changes suddenly for the worse and whether an agency nurse can see patients within 48 hours of hospital discharge.

The practice pays Advance a contracted rate that’s better than the LUPA rate for each patient visit. To offset costs associated with patient emergencies, Advance can count on referrals for standard home care by VCU’s house calls physicians, says geriatrician Peter Boling, who heads the VCU program (*HHL 10/1/12*).

The close working relationship with VCU’s house calls physicians has ballooned the agency’s referrals of the hospital system’s patients generally. While 10 to 20 of the patients enrolled in the house calls program are referred for home health episodes each month, overall referrals from VCU Health System’s hospital now are averaging around 150 a month, compared with the pre-demo rate of only 20 or so a month, says Norman Davis, Advance Care’s chief operating officer.

Aside from the growth of referrals, Advance Care’s close working relationship with VCU’s house calls unit has gained

it access to patients’ hospital records. That has reduced the likelihood of being “blindsided” by patients whose home care needs turn out to be greater than expected, Davis says. — *Burt Schorr* (burt.schorr@verizon.net)

ICD-10 coding

2017 guidelines: Hypertension, heart disease can now be assumed to be connected

In a complete reversal from previous guidance, coders can now assign I11.0 (Hypertensive heart disease with heart failure) for a patient with diagnoses of hypertension and heart failure, regardless of whether the physician has linked the hypertension to the heart failure.

“The classification presumes a causal relationship between hypertension and heart involvement ... as the two conditions are linked by the term ‘with’ in the Alphabetic Index,” according to the 2017 fiscal year official coding guidelines, which took effect Oct. 1. “These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.”

The heart conditions that can be assumed to be connected to hypertension and therefore coded as hypertensive heart disease range between I51.4 (Myocarditis, unspecified) and I51.9 (Heart disease, unspecified), according to the alphabetic index.

Additionally, conditions categorized to I50.- (Heart failure) also can be assumed to be connected to hypertension when both occur based on the “see Hypertension, heart” note that falls under “with” in the alphabetic index.

You must follow the word “see” to where it leads before you can be assured you’ve arrived at the right code, says Trish Twombly, senior director for DecisionHealth in Gaithersburg, Md. The “see” is a mandatory instructional note that falls among the coding conventions.

Additionally, heart failure conditions coded to the I50.- category are mentioned in the updated FY 2017 hypertensive heart disease guideline as assumed to be connected to heart disease unless another etiology has been given.

This guideline update amounts to a monumental shift: Previous longstanding guidelines stipulated the physician must connect a patient’s hypertension with his or her heart disease or heart failure in order to assign the

combination code, and only chronic kidney disease was allowed to be assumed to be related to hypertension.

The shift will be keenly felt by Maurice Frear, a coder for Bon Secours Home Health and Hospice Services of Virginia Beach. For Frear, seeing heart failure patients with hypertension is “almost a daily occurrence” and only very rarely does he see someone with heart failure who doesn’t have also have hypertension.

As a result, Frear will make less use of I10 (Essential hypertension, unspecified).

More 2017 guidelines changes

Here’s a brief summary of additional guidelines changes that went into effect Oct.1:

- **Assign both pressure ulcer codes** (one for the ulcer at its initial stage and one for the ulcer at the stage to which it progressed), at recertification, follow-up or resumption of care, when a patient’s pressure ulcer has progressed to a worse stage during the admission.

Clarification on this guideline is currently being sought, but in the meantime, sequence the pressure ulcer stage codes according to the seriousness of the condition, Twombly says.

- **Don’t assign the bilateral code for a condition if a previous encounter resolved the condition on one side of the body**, and the present encounter is treating the other side.

For example, don’t assign a code for bilateral cataracts if the patient’s right eye cataract was treated and resolved and the present episode is caring for cataracts in the left eye. Instead, only assign the code to indicate the left side where the condition still exists. — *Megan Batty (mgustafson@decisionhealth.com)*

Survey prep

Supervisory visits ensure agencies maintain quality, standards

Administrators should use supervisory visits for nurses and therapists — in addition to aides — as a strategy for communicating clear expectations for staff. Such visits will ensure agency standards are met and patients are receiving high quality care.

Regulatory requirements for supervisory visits for therapy and nursing staff can be different than those for home health aides.

Emily Nelson, quality regulatory coordinator for Bellin Home Health Agency Green Bay, Wis., says supervisory visits for nurses and therapists at her agency have evolved over time into a robust practice with a detailed tool used to document assessments.

“We want to make sure staff is caring for patients up to our requirements,” Nelson says. Her agency’s supervisory visits focus on making sure patients are safe and are built around the Joint Commission’s National Patient Safety Goals.

Supervisory visits are performed by supervisory staff in the same discipline at least once annually but may occur more frequently. “We’re regulated by The Joint Commission, but it’s really what the agency dictates,” she says.

Nelson says whether supervisory visits for nurses and therapists are performed are left to the discretion of the agency. She says they are not mandated by state or federal rules.

For aides, Nelson says, her agency conducts supervisory visits every two weeks in accordance with CMS regulations.

CMS requires supervisory visits of aides as a Condition of Participation in Medicare. CMS mandates that nurses or therapists perform onsite visits every two weeks to oversee the work performance of home health aides.

“It ensures that the aide is completing what tasks are on their assignment sheet, and the patient is receiving that care,” says consultant Rebecca Friedman Zuber, formerly the director of Illinois’ state survey office.

Customized tool tracks supervisory visit

The supervisory visit tool developed by Bellin for its nurses and therapists is divided into seven topic areas: General, infection prevention, safety/risk, care planning, medication review, satisfaction/customer service and a final section that addresses the accuracy of OASIS documentation.

The tool focuses on risk as reflected in the OASIS-C1 assessment and in outcomes questions. “We want to focus on those risk items and make sure we’re assessing and teaching on those items with the patient and caregiver,” Nelson says.

As of a few months ago the agency had not yet reviewed how OASIS-C2, which is set to become effective in January, would impact the way the agency conducts its visits. The agency has regular OASIS trainings and education sessions for clinicians, so they are aware of any changes, Nelson says.

The tool also helps monitor how different disciplines are communicating, Nelson says. For example, if a physical therapist is notified by another clinician or aide that the patient is having a lot of pain, then that therapist may want to alter the plan of care (POC), an action that should demonstrate effective communication between clinicians.

Focus on clinician specificity

In the supervisory visits at Bellin, clinicians are assessed on use of patient identifiers with new patients or those that the clinician has not seen in a while, Nelson says. Clinicians should ask for the patient's name and date of birth, or as a secondary identifier, the patient's address.

Clinicians also are assessed on how they manage privacy concerns. "If we arrive and there are friends or family around, and we have to do wound care or skin check, we may want to ask if they want to go into another room," Nelson says.

Zuber says the function of the aide needs to be understood so that if there are problems they can be addressed.

As for supervisory visits of aides, "I tell agencies they should have the aide present for the visit so there is communications on what needs to be changed and what needs to be improved. It's a real benefit." Zuber says.

Tips for conducting supervisory visits

- **Perform aide evaluations during each clinical visit.** That's a way to prevent being cited for not performing visits on time, Zuber says.

- **Have "like" disciplines supervising staff.** For example, an RN supervisor would conduct with the field RNs and CNAs, a therapy team facilitator would conduct the therapy staff and so on. — *Kathy A. Gambrell* (kgambrell@decisionhealth.com)

CoPs

(continued from p. 1)

Within CMS' current proposal, one requirement calls for agencies to verbally inform patients and their representatives of patients' rights in a language and manner the individual understands during the initial evaluation. Moreover, language assistance services or auxiliary aids must be provided to patients or their representatives at the agency's expense.

Although the requirement to properly communicate rights has existed in federal limited English proficiency

Proposed CoP Prep

Wait before getting your patient rights forms translated into various languages

Agencies should act now to determine what languages they'll need their patient rights forms translated into once the proposed home health Conditions of Participation (CoPs) are finalized. They'll need to adapt their documents to meet the language needs of patients and caregivers.

But when it comes to paying to get forms translated now into additional languages, it would be prudent to wait until the CoPs are finalized, contends Bill Dombi, vice president for law for the National Association for Home Care & Hospice (NAHC).

To help ensure proper communications, the American Hospital Association has suggested CMS create a consumer website to provide information about patient rights in layperson's terms in multiple languages. In a Jan. 5, 2015, letter, the hospital association reasoned that a CMS-sponsored website would ensure standardization as the regulatory language is translated and disseminated to a wide audience.

The association also suggested CMS provide similar resources, such as templates in multiple languages for other requirements, including templates for discharge and transfer policies.

"If they want information portrayed in a specific manner, in a way that they believe is most understandable to patients, it would be really helpful to have a template, a standardized form, or at least a good example," Nancy Foster, the hospital association's vice president for quality and safety patient policy, tells *HHL*.

Costs to get forms into the languages you need could add up.

Clearwater, Fla.-based translation service Stratus charges \$20 or less for translating the first page of a document, then by the word on subsequent pages. Charges for translations depend on the length, technicality and target language. Languages spoken by fewer people generally cost more to interpret or translate because there are fewer people available to provide that service. — *B.C. Manion* (bc.manion@gmail.com)

regulations for years, adding it to the CoPs is expected to raise scrutiny by state surveyors, industry experts say.

Translation service offers its insights

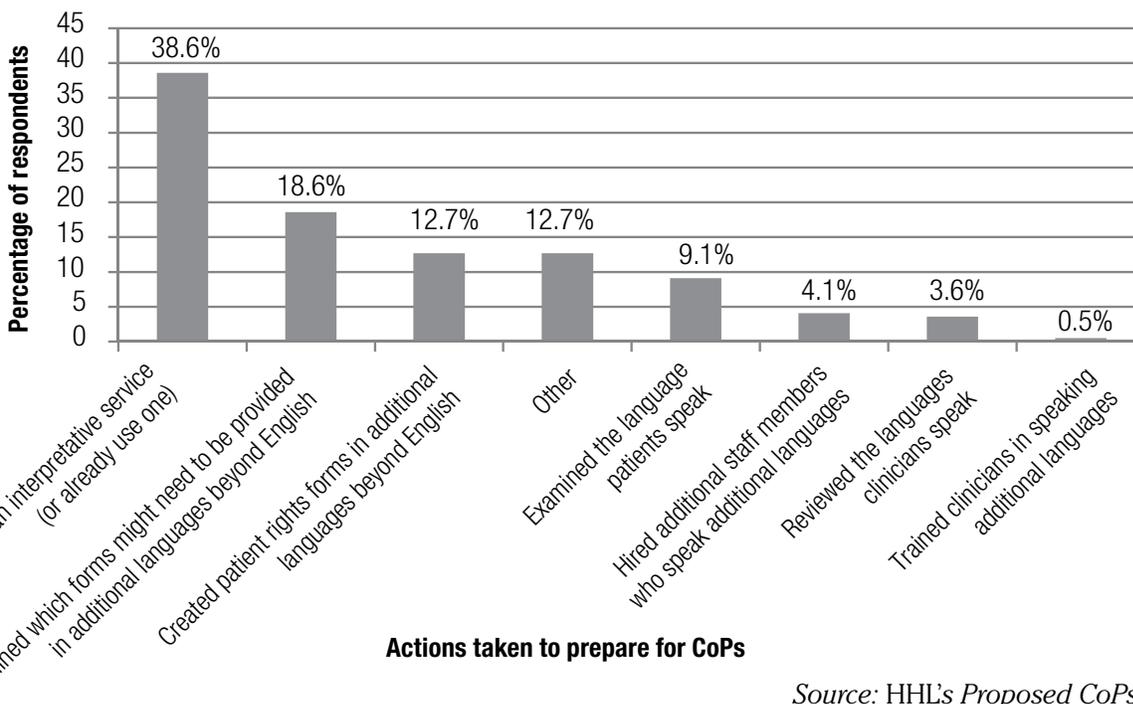
There are a number of translation and interpretative services available for agencies to consider.

Some services, such as Stratus, based in Clearwater, Fla., provide remote live video, in-person or over-the-phone interpretative services working around the clock. Its

BENCHMARK of the Week

What patient rights changes has your agency made to comply with the proposed CoPs?

Nearly 39% of the 220 respondents to a question on *HHL's Proposed CoPs Survey* said they have hired an interpretive service (or already use one) due to the proposed patient rights Condition of Participation. (See story, p. 1.)



Source: *HHL's Proposed CoPs Survey*

video interpreters are available in 17 languages. Its audio interpreters are available in more than 200.

“In terms of need, Spanish is definitely the lion’s share,” says Kate Pascucci, the company’s marketing director.

In terms of delivery system, “Video is very popular at the moment,” she says. “It’s on-demand. It’s quick. And, there’s much less expense than bringing an on-site interpreter in.”

When agencies work to hire a translation service, they need to compare how much the services cost and get a sense of the turnaround time for translating documents. Stratus charges \$1 to \$10 per minute for video interpretations.

The company’s rate is slightly less for over-the-phone interpretations, the industry standard for years. However, there has been increasing use of video remote interpreting during the past five years because of the visual cues it provides.

Other language services include Certified Languages International, with locations in Portland, Ore., and Phoenix. It offers interpreters in more than 200 languages

and document translation in essentially any language. Its services include over-the-phone interpretation, video-remote interpretation and document translation.

There’s also CTS Language Link, based in Vancouver, Wash. It provides interpretation in 240 languages and translation services in more than 100 languages. It offers telephone interpreting, on-site interpreting and document translation.

Note: According to a rule issued in May by HHS’ Office of Civil Rights (OCR), covered entities should only use video interpretation services if they meet high technical standards, e.g. “a sharply delineated image that is large enough to display the interpreter’s face and the participating individual’s face regardless of the individual’s body position.”

Actions agencies should take now

- **Examine what languages your patients speak and ask yourself how you currently communicate with those patients.** Conduct a survey to make sure you truly understand your gaps.

Have the person at your agency in charge of compliance with OCR regulations perform this task, advises attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman.

- **Prepare a list of questions when you investigate your translation service options.** Among the important issues to ask about: Which languages are available and are they available 24/7? What are the delivery options?

- **Ask translation services to show you the interpreters' certifications.** Stratus will provide an interpreter's certifications upon request.

If a certification is unavailable in a specific language, ask what training is required and how skills are assessed, such as third-party testing, demo calls and medical terminology exams.

- **Be sure the service provider is HIPAA-compliant.**

- **Note that you can hire translation services on a contractual basis, or as needed.** If there is no contract, it's a good idea to establish a strong relationship with a freelance interpretation agency, to ensure 24/7 access. — *B.C. Manion (bc.manion@gmail.com)*

Reviews

(continued from p. 1)

reimbursement. This has created a cash-flow bind that so far has forced at least one agency to shut down. A number of the turndowns involve physical therapy following hip replacement surgery.

- **One agency received non-affirmation and then affirmation — without changing a thing.** The agency resubmitted the documentation that led to a MAC's initial refusal to affirm the agency's services. The agency received notice — without explanation — that reimbursement for the services were justified.

- **The demonstration has sown "confusion and fear" among beneficiaries** by requiring MACs to notify them by letter that their agency's pre-claim submission has been denied. Beneficiaries are interpreting the letters to mean Medicare won't pay for their health care, and when beneficiaries call Medicare for an explanation, "the operators don't know what pre-claim review is."

- **The demo is delaying hospital discharges,** forcing orthopedic and other home health candidates to extend hospital stays. A day spent in an Illinois hospital costs an average \$2,025 compared with only \$168 for a home health visit, the summary of the pre-claim demo compiled by the Illinois Home Care & Hospice Council notes.

Even though CMS postponed the demo in Florida, Texas, Michigan and Massachusetts, the federal Medicare agency is allowing it to continue in Illinois (*HHL 9/19/16*). It believes "additional education efforts will be helpful before expansion of the demonstration to other states," a spokesman says. "CMS is working closely with its contractors on revised education and outreach efforts in both Illinois and Florida."

Please pass this coupon to a colleague who could benefit from a subscription to Home Health Line.

YES! I want the latest business and regulatory news, benchmarks, best practices and executive tools to increase my profitability and ensure agency growth. Please enter my one year (48 issues) subscription at \$597 for *Home Health Line*.

Name: _____

Org: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Fax: _____

Email: _____

www.homehealthline.com

Payment enclosed. Make checks payable to *Home Health Line*; (TIN: 26-3622553)

Send me an invoice (PO _____)

Charge my:    

Card #: _____

Exp.Date: _____

Signature: _____

Mail to: **Home Health Line**

Two Washingtonian Center, 9737 Washingtonian Blvd., Ste. 502, Gaithersburg, MD 20878-7364 | 1-855-CALL-DH1

PAS 2016

HHL contacted CMS to see why the demo is continuing in Illinois, but did not receive a direct response.

HHL also contacted Palmetto about the demo's early results and why the three-year demo is continuing in Illinois despite the delay in Florida, but has not yet received a response.

Illinois agencies are living “a nightmare”

For Illinois agencies, the demo “has been a nightmare,” says Kathy Domenz, an Arlington Heights, Ill., coding consultant who assisted six agencies to prepare documents in support of their pre-claim submissions.

Domenz, who has 30 years of experience with Medicare reimbursement, believes all those submissions met requirements for payment.

Yet MAC Palmetto GBA so far has refused to authorize 90% of them, forcing her clients to wait another 20 days for payment while resubmissions are pending, she relates.

Agencies say reviews are unpredictable

Another problem for Illinois agencies is that MAC decisions on authorizing claims have been unpredictable, many agencies contend.

St. Frances Home Care Services in Peoria, for one, has submitted more than 500 claims for advance authorization and Palmetto has turned down about 40% of them — including care of an 81-year-old woman discharged from the hospital with COPD exacerbation, respiratory failure, dementia, urinary tract infection and a recent fall.

The woman's care needs include oxygen, nebulizer treatments and multiple inhalers requiring education and monitoring, says Sheila Guither, clinical practices manager for St. Francis Home Care Services.

Consequently, the patient's plan of care called for: Nursing visits for assessment, overseeing new or changed medications and education; PT visits partly in response to the patient's weakened condition resulting from her hospital stay; OT, also for weakness and for oxygen conservation; ST for dementia; and an aide for assistance with bathing and personal care.

Palmetto's finding, which St. Frances is contesting with a resubmission, was that “the physician certification was invalid since the face-to-face was not performed by an approved practitioner.”

In fact, the non-affirmation is inaccurate because “the face-to-face was completed by a qualified advance practice nurse and co-signed by the attending physician,” the agency contends.

For now, it is caring for the patient at a cost of about \$3,000 per episode, Guither says.

Mary Newberry, director of transitional and home-based care at Riverside Medical Center in Kankakee, is just as frustrated by her agency's 61% non-affirmation rate.

The turndowns are mostly based on lack of MD documentation to support the need for skilled care or show homebound status.

Newberry suspects the cause is Riverside's development of an electronic pathway that automatically creates a face-to-face form for physicians to fill out.

Palmetto's reviewers “don't appear to recognize this as a piece of physician documentation,” she says.

One patient Newberry's agency is caring for without certainty of being paid is a 69-year-old male referred for therapy and nursing following hospitalization for a revision of his left hip replacement due to an inflammatory reaction.

The orders for nursing were related to wound healing and medication teaching.

The patient has comorbidities of heart failure, atrial fibrillation and past stroke.

The patient was discharged with instructions for limited weight bearing by the artificial hip joint and therapy for gait, balance and safety.

Palmetto's pre-claim judgment: The claim can't be affirmed because the face-to-face encounter document from the doctor “does not support” the need for nursing or therapy. ” — *Burt Schorr* (burt.schorr@verizon.net)

Correction

An Aug. 1 *HHL* article on CMS' pre-claim review should have quoted Palmetto GBA Vice President Ed Sanchez as saying: “The ePortal solution allows for immediate feedback, acknowledgement and processing into our workflow while other modes could experience delays. For example, it could be a delay of one day for fax or three days for standard mail before being ingested into our workflow.”

In all instances, Palmetto is prepared to process pre-claim reviews regardless of submission mode within the mandated 10-workday adjudication requirement, Sanchez added.

How did you get this email?

It is illegal to forward **Home Health Line Online** to anyone else.

It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute **Home Health Line Online** to others in your office or other sites affiliated with your organization.

If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, **only the party who forwards a copyrighted email is at risk**, not you.

Reward: To confidentially report suspected copyright violations, call our copyright attorney Steve McVeary at 1-301-287-2266 or email him at smcveary@ucg.com. Copyright violations will be prosecuted. And **Home Health Line** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of **Home Health Line Online** or photocopying of our newsletter.