

**CROSS YOUR T'S AND
DOT YOUR I'S**

**ENSURING ACCURATE AND THOROUGH
DOCUMENTATION UNDER PPS**

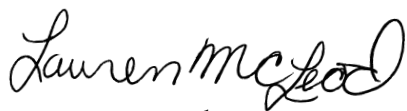
Dear Reader:

Documentation has always been important in home health care, as it is in every health care setting. Effective documentation

- tells the story of the patient and his or her individual care
- provides the basis for coverage and reimbursement
- protects the clinician and agency from allegations of fraud or poor practice
- gives the agency information for benchmarking
- validates the standardization of care and care practices
- acts as the basis for reviews related to quality of care and reimbursement
- communicates and coordinates care among team members

In the new era of PPS, accurate, thorough documentation can mean the difference between an agency that thrives and one that doesn't survive. In this special report, we have compiled information and tips on a variety of documentation issues, including demonstrating medical necessity and homebound status, coding, and ensuring OASIS accuracy and consistency with the medical record.

Best regards,



Lauren McLeod
Managing Editor

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*Editor's note: The information for this special report was taken from reports from home care seminars and conferences, and previous issues of **PPSAHH** and Home Care and Hospice Update, which was recently acquired by **PPSAHH**'s publisher, Opus Communications, a division of HCPro.*

Documentation should clearly outline medical necessity and homebound status

Although PPS presents a major shift in reimbursement philosophy and incentives, it is critical to understand that the actual coverage for Medicare home health services has not changed.

The criteria used to determine patient and service eligibility are found in the *Health Insurance Manual Publication 11 (HIM-11)*. The two key elements that must be addressed in the clinical record are medical necessity and homebound status.

Documentation is the major key to applying this coverage criteria on a day-to-day, patient-by-patient basis. Whether an agency review manager or a medical reviewer representing a fiscal intermediary is reviewing a case, the only way to determine the appropriateness of the services is by reviewing the clinical documentation in the record.

Writing a series of clear, objective statements is the best way to prove that a patient is homebound and requires medically necessary services. Instead of focusing on any single characteristics, these statements should progressively eliminate the reviewers' doubts about the patient's status.

Medical necessity

Ask yourself these questions to determine medical necessity:

- Are the services “skilled” as defined by Medicare?
- Are the services required inherently complex, so that they can be performed safely and/or effectively only by or under the general supervision of a skilled clinician (nurse or therapist)?
- Does the patient's condition require specialized knowledge and judgment of a qualified clinician who can carry out the program and achieve the treatment goals?
- Are the services “reasonable”?
- Are the treatments consistent with the patient's illness or injury?
- Are the treatments and visit frequencies moderate and rational (as opposed to excessive or

inadequate) in relation to the patient's unique medical condition?

- Are the services “necessary” in that they are essential to meeting the standard of care and service for the patient?
- Will the patient's condition materially improve as a direct consequence of the treatments and home care provided?

Homebound status

In documenting the patient's homebound status, clinicians should include much supporting detail describing the patient's status, including any physical, cognitive, medical, or environmental issues that affect the patient's ability to leave the home.

Below are the conditions that define homebound status, according to the *HIM-11*, followed by suggestions for supporting the definitions through patient-specific details:

- **Leaving the home requires a “considerable and taxing effort.”** Document physiological findings to support the fact that leaving the home is taxing, such as specific measures of pain, shortness of breath, and increased edema.
- **An illness or injury that restricts the ability to leave the home except with “supportive devices,” “special transportation,” or “assistance of another person.”** Document and describe all equipment the patient needs to leave the home, such as a walker, splint, gait belt, oxygen tank, as well as any special transportation needs, such as a ramp, lift, or vehicle adaptation. Explain the type and level of help provided—for example, moderate assistance with steps or moderate assistance of two for car transfer.
- **Absence from the home is medically contraindicated.** Document any and all medical issues and restrictions that would keep the patient at home, such as immunosuppression, open wounds, limb positioning, or immobility. 🏠

Correct coding takes on new importance under PPS

Look up a patient's diagnosis. Find the corresponding code. Write it on the Outcome and Assessment Information Set (OASIS) and 485 plan of care. It sounds simple enough, but it's not as straightforward as it seems.

Multiple codes can be reported for a single patient. Certain codes increase reimbursement rates. Others cannot be listed as primary diagnoses. Many codes need a fourth or fifth digit to be accurate.

It's imperative for home care professionals to understand and follow the guidelines for proper coding, particularly under PPS, according to **Michelle Dougherty, RHIA**, practice manager for the American Health Information Management Association.

Understand the significance

If home care professionals don't understand and follow the guidelines for proper coding, their agencies could be vulnerable to missing out on reimbursement they are entitled to, or—just the opposite—accusations of fraud.

Unlike the inpatient setting, where a PPS has been in effect since the early '80s, reimbursement under the home health PPS is not based solely on the ICD-9-CM codes. However, these codes are an important part of the larger OASIS, which determines payment.

"A significant number of points in the clinical dimension come from the diagnoses reported in M0230 and 240, the primary and secondary diagnoses," explains Dougherty.

Certain diagnoses result in an additional 11, 17, or 21 points, which adds up to a higher reimbursement rate.

But without a proper understanding of coding guidelines and reporting rules, agency staff won't be coding diagnoses appropriately, which will result in inaccurate data, inappropriate payments, and compliance risks.

In the acute care setting, health information man-

agement professionals with coding training and/or credentials are usually the ones assigning codes.

But in the home health setting it's often field nurses or office staff who haven't learned the ICD-9-CM coding rules or read the guidelines.

And because it's crucial to get the OASIS out the agency door as soon as possible, there's not much time for checking and double-checking.

"The biggest problem in the industry is lack of training," says Dougherty. "Many of the people assigning codes have never used an ICD-9 book. They've never been trained how to use the ICD-9 book. They're selecting diagnoses off a list. They're not obtaining physicians' supporting documentation."

Code off the record

When deciding what diagnosis code or codes are appropriate to best describe a patient's condition, it's imperative that your determination be based entirely on the physician's documentation, says Dougherty.

"One of the standards of ethical coding is that when you attach diagnosis codes, you base it on physician's supporting documentation," says Dougherty. "So often in home care, you don't have somebody transferring to your agency right out of a hospital or a nursing home, but they're home and they give you a call."

In those cases, since there's less official documentation, staff may be tempted to use the patient's perception of their diagnoses to decide what to assign. If they do that, "the accuracy can be significantly compromised," explains Dougherty.

Instead, staff members need to obtain copies of the physician's orders that document the reason for the admission.

If the patient was hospitalized "within a period that makes some of the information relevant still," it is a

good idea to get copies of records from that stay, says Dougherty.

“It certainly helps when you’re looking at some definitive diagnoses and trying to get something supporting what you’re assigning.”

Pick out the primary diagnosis

Once you have the documentation you need, it’s time to decide which code goes where. The OASIS calls for one primary diagnosis code, and allows up to five secondary diagnoses to be listed.

“One of the biggest problems—and a lot of it has to do with the lack of official direction—is how to decide what’s primary and what’s secondary,” says Dougherty.

“Many patients come in with multiple diagnoses. It’s common when you get into extended care situations.”

When you’re sequencing the diagnoses, Dougherty recommends asking the following questions:

- What is the most acute condition you’re treating?
- What requires the most skill?
- What requires the most resources or services?

The answers to these questions will help you to determine which diagnosis should be considered primary.

Alan Sabroski, RN, BA, president of ScanHealth, Inc., suggests consulting the physician if you’re unsure about which diagnosis is primary.


Avoid these tricky traps

If staff members are using cheat sheets or pick lists, instead of coding books and physician documentation, they are likely to choose the wrong code or put a code in the wrong place.

Based on official coding guidelines, there are certain diagnoses that can never be listed as primary, because the underlying disease must always be listed first.

“Those diagnoses, if appropriate, *continued on p. 6*

Twelve tips for ensuring accurate coding at your agency

1. Educate clinicians and clinical managers about the importance of analyzing and reviewing for the correct diagnosis and coding information
2. Make sure you have the most up-to-date materials on hand
3. Read and review coding guidelines and OASIS instructions
4. Don’t use pick lists or cheat sheets
5. Delineate to a fifth digit whenever appropriate
6. Create a standardized process for a random prebilling audit with a review of the coding information (OASIS, 485 plan of care) from referral through care
7. Design a process to aggregate and trend patient diagnoses at regular intervals
8. Direct coding staff members to refer questions to the clinical manager for resolution
9. Develop coding-specific competency programs for the home care coder
10. Incorporate industry-approved standards of ethical coding into compliance activities
11. Consider joining professional health information management organizations, such as the American Health Information Management Association
12. Review coding and billing topics that have been identified by the Office of the Inspector General 

would be reported in the first field in the secondary diagnosis question on OASIS,” says Dougherty.

For example, code 320.7, meningitis and other bacterial diseases, must be placed in the secondary diagnosis category, with the underlying condition—such as typhoid fever—placed in the primary spot.

“Before you code the meningitis, [you have to code first] what the underlying condition is that caused meningitis and this other type of bacterial disease,” explains Dougherty. “This is confusing for anyone who’s never gone through training.”

Keep in mind compliance concerns


Whether a code will increase reimbursement should have nothing to do with the decision to place it in the primary or secondary diagnosis spot, warns Dougherty.

She says she has seen cases where a diagnosis that would increase reimbursement was listed as primary, even though one of the secondary diagnoses was more acute and required more services.

“Maybe somebody has five diagnoses and one of them will bump up the reimbursement, but it’s not necessarily the primary reason, but they’ll report it there anyway because it’ll increase reimbursement,” says Dougherty.


“That is a huge compliance risk. They’re going to be able to tell that you’ve got so many services for a certain condition, but you reported something else that bumped your payment up as the primary diagnosis.”

“And they can take [payment] away,” Dougherty adds. “So, you’re risking reimbursement—that some of that payment that you did receive would be taken away. And if [fiscal intermediaries] see that what you’re doing appears fraudulent, the medical review team has been trained to report fraudulent behavior to the OIG [Office of Inspector General] for investigation.”

“I think the biggest threat—because every agency will face this—is medical review by their fiscal intermediaries,” says Dougherty. “And what the reviewers are going to look for is that you can support the fields on the OASIS with supporting documentation.” —

Sample coding procedure

Each agency should have a procedure that outlines who gathers the necessary information for coding, who enters the codes into the appropriate forms and systems, and who reviews the codes for accuracy. Here is a sample:

1. Central intake receives referrals that include one or several medical diagnoses, either by phone from referral sources or from case managers at affiliated hospitals.
2. Patient is assigned to an appropriate team based on clinical need and geographic location.
3. Admitting clinician opens case, assesses patient, and determines appropriate primary diagnosis, and secondary diagnosis if applicable, from previously identified diagnoses noted on the referral. The primary and secondary diagnoses are indicated on the OASIS and the referral form.
4. The admission packet is submitted to the appropriate patient care manager, who reviews the admission assessment and ensures that the appropriate diagnosis has been chosen as primary, based on the patient’s identified home care needs.
5. A medical data entry transcriptionist or other trained coding team member codes the diagnoses that have been indicated by the clinician or manager and enters these codes into software and other systems. —

Consistency is key in completing OASIS forms

One of the biggest problems **Joan Sourapas, MBA**, partner at CurranCare, in North Riverside, IL, has found in reviewing her clients' OASIS forms is that the answers often didn't match up with the rest of the documentation in the patient record or even with each other.

In some cases, even though wound care was the primary diagnosis, there was no indication of any wounds in the OASIS form. In others, the discrepancies are less obvious, including answers that indicate patients could move around easily, which contradict other responses that indicate the patient had little or no mobility.

That's why **Helen Siegel, RN, MBA**, clinical and regulatory coordinator for the Home and Health Care

Association of Massachusetts, says it's important to have a manager who understands the OASIS questions review each nurse's assessment before it's submitted for billing purposes. That manager should be willing to ask nurses questions about their responses to make sure they are consistent, not only with the other questions on that OASIS form, but with the responses on similar patients' assessments.

Even more helpful than simply reviewing assessments that have been completed in the field is accompanying your clinicians on visits and watching them conduct some assessments, says Sourapas. "There is an even greater opportunity, actually, when you go into the patient's home and see the types of questions asked and the responses," she adds. 🏠

Check referring facilities' licenses and keep a list

"From which of the following inpatient facilities was the patient discharged during the past 14 days? (Mark all that apply.)" It seems like a simple enough question. But even this question has intricacies that are important to keep in mind.

"Even something seemingly objective as 'where was the patient 14 days ago' could be a trick question," says **Helen Siegel, RN, MS, MBA**, Clinical & Regulatory Coordinator at the Home & Health Care Association of Massachusetts.

Home health agencies receive lower reimbursements for patients who have been cared for in inpatient facilities before receiving home health services. In the past, "patients who were admitted to home health from the community used more services than patients coming out of a hospital or a skilled nursing facility [SNF]," says Siegel. That's why agencies receive a higher reimbursement for patients who haven't received recent inpatient care.

Consider the following scenario: a patient has stayed in a transitional care unit (TCU) for two and a half weeks, where "he received nursing services, fairly in-

tense rehab services, a social service and nutrition consult, along with assistance with his personal care."

Which of the choices on the OASIS do you select—hospital, rehabilitation facility, nursing home, other, or N/A?

It depends. TCUs can be located in hospitals, rehabilitation facilities, and nursing homes, so it's important to check the license of the referring facility to find out what type it is, rather than relying on the name of the facility or trying to determine its designation based on the services it provides, says Siegel.

"It goes back to state licensing," she says. "You have to know how the facility is licensed." It's incorrect to assume that a patient who was receiving rehabilitation services must have been treated in a rehabilitation facility. It's just as likely to be licensed as a hospital or SNF.

She suggests agencies go through a list of the facilities that give them the majority of referrals and find out how each is licensed. All staff members at the agency who fill out OASIS forms should refer to the list when answering this question to prevent errors. 🏠

Take five big steps toward correct assessments of patients' activities of daily living

Ask a nurse how a patient performs activities of daily living (ADLs). Ask a physical therapist (PT) or occupational therapist how the same patient performs ADLs. You're very likely to get two completely different answers, says **MaryBeth Augustin, RN, MSN**, senior associate with CurranCare, a health care consulting company based in North Riverside, IL.

"The trend we're seeing is that the OASIS responses do not correlate with the occupational or therapy notes," she says. "That's a major, major problem. When I look at the OASIS and I look at the PT notes the next day, they don't match. The PT usually grades the patient as being a lot worse."

This inconsistency can prove problematic for a number of reasons. First of all, if the nurse conducting the initial OASIS assessment scores the patients lower on the ADLs than is appropriate—for example, answering that a patient is able to dress his or her lower body without assistance, even though the patient can't bend over far enough to put on shoes—then the payment for the patient will be lower than it should be.

"The most opportunity I see for agencies in terms of improving data quality and recovering reimbursement is in the ADLs, because I don't think nurses are used to doing such in-depth assessments," says Augustin.

Secondly, if the patient's record is taken for medical review and the plan of care doesn't match up with OASIS and the documentation, the claim could be denied, and the agency could be open to accusations of fraud and abuse.

Take the following five steps, and you're on your way to more accurate assessments:

1. Stop relying on interviews.

Nurses tend to ask patients questions about their ability to move around and perform simple tasks,

instead of watching to find out what they can do.

Many studies have shown that patients tend to evaluate their condition or health status higher than it really is "either because that is how they think of themselves, [or] they're afraid that they won't be able to remain at home if they're too dependent," says **Helen Siegel, RN, MS, MBA**, clinical and regulatory affairs coordinator for the Home & Health Care Association of Massachusetts, Inc.

They also may think they're telling you what you want to hear, she says.

"[Nurses] cannot take the patients' word for it" about whether they can get dressed or go to the bathroom on their own, because they may be embarrassed or simply overestimating their own ability, Augustin adds.

"The difference between a nursing assessment and a therapist assessment is the therapist is saying, 'Show me,' " says **David Macke, MBA**, director of reimbursement services at VonLehman & Company, Inc.

2. Instruct nurses on therapy techniques.

Make sure nurses do what therapists do—get the patients moving around so that they can evaluate their ability to walk, bend, and reach, says Augustin.

"Stand the patient up, have them put one foot in front of the other in different spots, and determine their gait or their balance," she suggests.

"Another technique would be to observe, when the patient does get up, whether they utilize such things as armrests or the support of the walls, which can also indicate that they require the assistance of some device. Maybe they just don't have the device right now, and we're going to provide that to them."

3. Check patients' pain level.

Clinicians should be sure to observe the difficulty

patients encounter when performing different activities, not simply whether or not they can do them. For example, a nurse should not necessarily consider a patient who encounters extreme pain in conducting ADLs, completely independent in doing them, says Siegel.

“If you’re saying that the patient does have pain, and then when you get to some of the ADL sections, you indicate the patient is completely independent in all ADLs, this could be true,” she says. “But if the patient is really having pain, then maybe they do need some assistance.”

4. Get therapists involved in the assessments.

Nurses and therapists should work together to answer the ADL questions, says Augustin.

“Interdisciplinary communication is a big thing we’re emphasizing,” says Augustin. She suggests that nurses consult PTs on what they have seen the patient do and work with them to determine the most appropriate OASIS answers for the patient.

“What we’ve been recommending is to get therapy more involved in the OASIS. Have [PTs] go out with nursing staff to show them some of the tech-

niques they can use to come to the best and most appropriate answers,” adds Augustin.

Make it part of the therapist’s responsibility that the ADL questions are answered correctly. And in therapy-only cases, the therapist should complete the OASIS assessment rather than a nurse, suggests Augustin.

“Some agencies still send an RN [registered nurse] out initially. I think that it’s not really cost-effective, and it’s not an intervention that improves their data quality,” she says. “Therapists really are the best discipline to assess those ADLs.”

5. Talk to caregivers and family members.

Caregivers can also serve as a good resource in accurately answering OASIS questions in the functional domain, because they spend much more time with the patient than the clinician performing the assessment will be able to, according to **Laura Gramenelles, RN, BSN**, of Simione Central Consulting.

Caregivers often provide a more accurate picture of the capabilities of patients than the patients themselves can, so it’s important when possible to include them when conducting the assessment. 🏠

Seven tips for answering wound care questions correctly

1. Remember everything that qualifies as a wound.

All the OASIS wound questions depend on the answer to the first one, M0440: Does the patient have a skin lesion or open wound? If the answer is no, the patient won’t score anything on any of the other wound questions.

The assessment nurse should answer yes if the patient has at least one sore, skin tear, ulcer, rash, crust, or burn, says **Cynthia Hohmann, RN, CHCP**, vice president of Health Care Management Consulting, Inc. (HCMC), in Jacksonville, FL.

If the patient has surgical incisions—closed either by staples or steri-strips—reddened areas, central lines, PICC lines, implanted infusion devices, or venous access devices, the nurse should also answer yes, she adds. However, peripheral IV sites and ostomy are excluded.

“But if you’re going to be changing dressing for the area around [the ostomy], then the answer is yes,” she notes.

“I see the nurses are answering *continued on p. 10*

that the patient doesn't have a skin lesion, and then when I look in the record and the documentation, they actually do have some skin lesion that's in that group, whether it's redness to the skin or a scar, central line IV sites, and whatnot," says **Mary Beth Augustin, RN, MSN**, senior associate with Curran-Care, a health care consulting company in North Riverside, IL. "They would be considered a skin lesion, but they don't understand, and they're not documenting it."

2. Look for lesions on every patient.

In some cases, nurses aren't looking for wounds because they're not the reason for admitting the patient, says Augustin. But in conducting initial visits, nurses need to assess patients thoroughly.

"If the patient is a high-risk patient in regard to diabetes or cardiovascular disease, they are in that risk category for pressure-type sores," explains Augustin. "You really need to inspect the body closely—especially those bony prominences—and look for signs of redness."

For example, a chronic heart failure patient who leads a rather sedentary life is likely to have a skin lesion, even though the wound has nothing to do with why he or she was admitted to home care.

"Really go in there to inspect the skin closely and look for those areas," advises Augustin. "You could easily have redness because they banged their elbow on a piece of furniture, and that would be considered a lesion."

In some cases, clinicians may not be educated about how lesions appear on patients with dark skin. Augustin advises that nurses "look for bluish or purplish discoloration of skin, or warm areas over those bony prominences" on darker-skinned patients.

In addition, just because you can't see a wound doesn't mean it's not there. For M0488, which asks about the status of the most problematic surgical

wound, Augustin says you don't have to answer "NA—No observable surgical wound" just because staples are hiding the incision.

"If it's a fresh surgical wound, you can rate it as early/partial granulation because it's in the healing process, instead of no observable wound," says Augustin.

3. Train staff in staging.

In the process of reviewing documentation for a client, Hohmann found one case in which a wound was listed as a stage 4 on the OASIS, stage 3 in the accompanying documentation, and stage 2 in documentation from the next day.

This scenario could raise all kinds of red flags in a survey or an audit. The fact that the wound was labeled most severe on the OASIS, which determines payment, and less severe in the accompanying documentation may lead to an accusation of upcoding—exaggerating the condition of a patient in order to get a higher reimbursement.

It also demonstrates that agencies are vulnerable to receiving lower payments than they deserve if wounds are not assessed correctly.

It's crucial for the nurses who are performing assessments to understand wound staging, or refer to someone else in the agency who is an expert to help them answer the OASIS wound questions, says Hohmann. It's imperative to have at least one wound care specialist on staff, she adds.

In determining the correct stage of a wound, nurses must remove the dressing and take a close look, says Hohmann. Call in a specialist if you're unsure, she adds.

"If there's a permanent dressing, call the physician to see what stage it is," says Hohmann.

One of the most common mistakes in completing the OASIS is restaging patients' wounds during

treatment, says Augustin. Whatever stage the wound was initially assessed as is the stage of the wound until it is completely healed, according to the national guidelines for pressure ulcers, she explains.

That's why it's critical to find out what the stage of the wound was initially, especially when a patient is transferring from a hospital or other inpatient facility.

"Try to gain more information from the office staff and the physician in regard to what level was the highest condition of the wound," says Augustin.

"When the nurse goes in, she may assess it as a stage two, but it was originally a stage three, and therefore it's always a stage three," she explains. "So you could lose significant points on that just by not knowing that bit of information."

But even when nurses know the initial stage of the wound, they mistakenly tend to upgrade it as the patient's condition improves.

"When you go from admission to recertification, admission to follow-up, if the patient had a significant change in condition, the nurse would be assessing it again and would want to show improvement or decline," says Augustin.

"So it's a tendency to either increase or decrease the stage—if they're getting worse it's a stage four, if they're getting better it's a stage two."

Nurses need to keep in mind that "once that wound has gotten to a stage four, it is always a stage four until it is healed. If they're backstaging, they're losing points."

4. Make sure the 485 diagnoses match the OASIS.

When answering the questions about whether the patient has a pressure ulcer, Hohmann explains that nurses should look at the location of the wound and keep in mind that if the answer is "yes," there should be a diagnosis on the 485 plan

of care, indicating that the patient has the wound.

Unlike pressure ulcers, stasis ulcers are caused by circulation problems. In answering M0468, "Does the patient have a stasis ulcer?" nurses should ask themselves, "Does [the patient] have other diagnoses that would support that it's circulatory?" says Hohmann.

5. Identify the most problematic.

To decide which wound should be considered the most "problematic," consider which wound is the largest, the most difficult to access, in the most advanced stage, and whether there is an infection in any of them, Hohmann suggests.

Fiscal intermediaries and surveyors will be reviewing other documentation to support that the wound you choose is in fact the most difficult to care for, she emphasizes.

6. Send out supervisors and specialists.

Augustin suggests sending supervisors and wound care specialists out in the field with the nurses conducting the assessments to evaluate their skills and make sure they are answering the questions correctly.

"You need to train as many staff as you can," says Augustin. "I think something that we really need to do is increase supervisory visits in the field with nursing staff to determine how they're getting their information, and identifying if it's consistent."

7. Snap some photographs.

If the clinicians who will be performing your assessment visits do not have expertise in wound care and you don't have enough specialists to visit every wound care patient, Hohmann suggests photographing wounds.

"Wound care cameras don't cost that much," she says, adding that they can actually save money in the end because wound stage will be correctly assessed, ensuring maximum reimbursement without the risk of inadvertent upcoding by inexperienced clinicians. 📷

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