

(Continued from page 3)

- 17 falls resulting in a death or serious disability; and,
- 14 surgeries performed on the wrong body part (12 in hospitals, 2 in ambulatory surgery centers)

In a positive outcome from previous years, there were no reported medication errors resulting in a death or serious disability. Previous years reported from three to eight medication error events per year.

In 2006, Indiana became the second state to adopt the National Quality Forum's reporting standards. The reporting standards are not intended as a comprehensive study of medical errors, but rather as representing a broad overview of healthcare issues. Prevention of medical errors generally requires a system-based approach. By focusing on a few fundamental prevention activities and an organized prevention system, errors can be prevented.

An emerging healthcare issue is healthcare associated infections. The State Health Department recently adopted hospital reporting rules for healthcare associated infections. Infection reporting will begin January 1, 2012. Hospitals will report central line associated bloodstream infections, surgical site infections, and catheter associated urinary tract infections.

"The new reporting rules are the result of a recent initiative led by the State Health Department to reduce healthcare associated infections in Indiana," said State Health Commissioner Gregory Larkin, M.D. "As the 15-month initiative comes to a close in December, we will continue to evaluate the data and look for meaningful ways to use it in order to protect the health of Hoosiers. I am confident we will see a reduction in healthcare associated infections in Indiana as a result of these new reporting requirements."

The 2010 Medical Error Report may be found on the Indiana State Department of Health's website at www.statehealth.in.gov.

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Upcoming Education Opportunities

January 12 ~ Webinar ~ Effectively Navigating the Complexities of FMLA ~ Lori McLaughlin, Westshore Senior Housing, & Carrie Flores, Krieg DeVault

January 19 ~ Quarterly Compliance Update with Becky Bartle ~ 12:30 pm ~The Marten House Hotel

January 31 ~ LTC Leadership Training ~ Kathy Johnson ~ LeadingAge Indiana Office

For full details, please look for brochures enclosed with this newsletter.

The Indiana Association of Homes & Services for the Aging (IAHSA) is changing its name to **LeadingAge Indiana**. Please look for a letter from Jim Leich, LeadingAge Indiana President, enclosed with this newsletter.

Mark Your Calendar  We Become 



Indiana Planning Demonstration Project on Dual Eligibles

News Briefs

HOPE attended a recent stakeholders meeting to learn about Indiana's interest in a demonstration project on how to better serve the needs of individuals dually eligible for Medicare and Medicaid. This would be through one of the several initiatives available through the Centers for Medicare and Medicaid Services (CMS) on dual eligibles that were part of the Affordable Care Act.

This meeting was the first of a series of meetings with stakeholders by the Office of Medicaid Policy & Planning (OMPP) to learn more about what is important to serving the needs of the duals. At the first meeting, OMPP shared information related to the opportunities provided by CMS for the development of integrated care programs for dual eligibles and how Indiana may participate in these opportunities. Future meetings will provide more time for participants to offer comments, suggestions, and to ask questions.

The focus of this initiative is how Medicare and Medicaid can work together to provide more coordinated

care and save money. Currently, the incentives of these two programs for this population work against each other. Since Medicare pays for hospital care, its incentive is to get the patient out of the hospital to a nursing home where Medicaid may pay and vice versa.

The following is a brief summary of OMPP thinking to date. They noted that few details were determined yet:

- Proposed Demonstration Goals:**
- Risk-based Managed Care Model (capitated);
 - Minimum of 2 distinct geographic service areas within the state;
 - Consideration of possible inclusion of HCBS participants;
 - Inclusion of LTC services for those members that are admitted to NF while participating in the demonstration;
 - Beneficiary Outreach begins for Enrollment by 12/31/2012.
 - Medicaid beneficiaries currently in nursing homes would not be included.

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December 2011 ~ Vol. 10, No. 12

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Mission
H.O.P.E. advances the interest of Hoosier owned and operated providers of healthcare, housing, and assistance services for the elderly.

Concerns were raised regarding how payment rates for providers would be set, whether all providers would be eligible for contracts with the managed care organizations, whether quality and not just price would be part of the contracting process, and consumer choice of providers. HOPE will be part of the advisory group as this process continues.

Be Prepared for Reduced Medicaid Remittances in January

The effects of the July 1, 2011 5% rate reduction and the increase in the Quality Assessment will be reflected in providers' January Medicaid remittance. HOPE has advised members of the likelihood that the State Plan Amendments (SPA) positively affecting Medicaid rates probably would not be approved prior to January 1, 2012. FSSA agreed to defer the implementation of the 5% rate reduction and the maximization of the Quality Assessment until the earlier of January 1st or the approval of the SPA. This was done in hopes of minimizing the cash flow impact of the July 1st changes. Unfortunately, the SPA has not been approved yet.

Last month HOPE provided its member facilities with estimates of the impact on cash flow for this state fiscal year (SFY) (July 1, 2011 – June 30, 2012.) If you have not received the estimate, or have any questions, please contact Bob Decker at the association office.

Notification Regarding Personal Needs Benefit for SSI Individuals in Nursing Facilities

The Division of Aging has been notified by the Office of Medicaid Policy and Planning that Medicaid SSI recipients in long term care facilities received notification that their personal needs benefit (up to a maximum of \$22) ended on 12-1-11. The notice sent was wrong and a new correct notice was sent on or around 12-6-11. Due to this error, some Medicaid members did not receive their typical check for December. The appropriate payment will be added to their January check. The correction will be done automatically and no further action is needed at this time. *(Karen Filler, Indiana Division of Aging)*



ISDH Answers Questions Regarding the New Bed Tracking System

As described in the November newsletter, the Indiana State Department of Health has instituted a new online bed and staff tracking system for nursing homes. Facilities should have received a notice of this new system and instructions. ISDH has received a number of questions about this new system and included the following information in the latest Long Term Care newsletter.

QUESTION: Are residential care facilities required to report in the Bed and Personnel Tracking System? We received an email directing us to report the information.

ANSWER: At this time, the ISDH is only requiring that nursing homes (comprehensive care facilities), including those that may have some licensed residential beds, complete the bed and personnel tracking information. Stand-alone licensed residential care facilities do not need to enter the information.

QUESTION: Please confirm that the ISDH Bed and Personnel Tracking System is due to you the first day of every month as you state "Bed availability data should be based on the last day of the month." Therefore, I need to see the nursing census for day's end (midnight) of the last day of the month before filling out the report.

ANSWER: You are correct. The bed census data should be based on the last day of the month. We therefore would like the information in the tracking system entered/updated on the first business day of every month. A day or two after the first business day is acceptable.

QUESTION: I don't see that the information is clear as to when our first report is due. Is it due on December 1, or early January for information relating to December 2011? If we submit on December 1, the information would be for November 2011. Please advise.

ANSWER: Facilities should begin entering data on December 1, 2011, or immediately thereafter, based on bed information as of November 30, 2011. Our goal was to use the December 1 update to get the data tables initially populated and make sure everyone could access the system.

QUESTION: We have primary care physicians and specialty physicians that some residents go to and some come in to the facility. Are they considered attending MD's? If so, what hire date would I put down if they are not paid by the facility? Our attending physicians would bill Medicare/Medicaid or private. The only MD or group paid by the facility is our medical director.

ANSWER: Attending physicians are the primary care physicians who come to see residents at the facility. The hire and termination dates are not mandatory fields so you can leave them blank for attending physicians. The "hire date" can be used however to help to keep track of the current attending physicians who work with your facility. Even though they are not employees of the facility, we recommend entering as the "hire date" the date when the physician began providing care to a resident at the facility and entering a "termination date" when that attending physician no longer has any residents in the facility. Entering a termination date will automatically remove that individual from the system.

QUESTION: When you have a patient that pays for a private room but is only counted once on the census - how does this affect your available beds?

ANSWER: If you have a room that technically has two licensed beds but one bed has been placed in temporary storage because the room is being used as a private room, then the bed in storage would be included as an available bed in the count. The bed is still licensed and it can quickly and easily be brought out and set up in the room.



Web interChange Makes Life Easier for Medicaid Billers!

Spending too much time on the phone getting claim status information? Not using Web interChange yet? Begin today – FREE. Web interChange allows providers to obtain claim status, submit claims, including secondary claims, claim attachments, and Medicare Replacement claims. Already using a software vendor to send claims? No problem - use Web interChange to resubmit claims requiring corrections.

Web interChange is a tool that allows you to re-

ceive member eligibility and send claim transactions online in a HIPAA format. Other features of Web interChange include:

- Provider Profile – Verify or make updates to your enrollment information without the need to use paper forms
- Financials – Review past payment information and download the weekly remittance advice
- Member Eligibility – Verify the status of a member's eligibility for Medicaid benefits
- Get Paid – Submit new, or correct previously submitted claims
- Get Trained – Your Field Consultant will meet with you to acquaint you with the features of Web interchange
- Get started. Complete the Administrator Request Form to begin using web interChange. You will be glad you did.

Go to <http://provider.indianamedicaid.com/general-provider-services/web-interchange.aspx>. *(Daryl Davidson, HP)*

State Releases Medical Errors Report

The Indiana State Department of Health has released its Medical Error Report for 2010. The annual report is based on the National Quality Forum's 28 Serious Adverse Events. The most reported event in 2010 was a stage three or four pressure ulcer acquired after admission to a hospital. In four out of five years, pressure ulcers have been the most reported event.

There were 107 reported events in 2010. This is slightly higher than the 105 events reported in 2007 and 2008 and is the most number of reported events in the five-year history of the report. Some of the increase is attributable to a 2009 change in the falls standard that likely resulted in an increased number of reportable falls events.

The most reported events in 2010 were:

- 34 stage 3 or 4 pressure ulcers acquired after admission to the hospital;
- 33 foreign objects retained in a patient after surgery (30 in hospitals, 3 in ambulatory surgery centers);

(Continued on back page)

Therapy Caps Extension Still Up in the Air

The annual issue of the Sustainable Growth Rate (SGR), aka the “doc fix” became wrapped up in the issue of extending the Social Security tax cut and unemployment benefits. The SGR formula called for an approximate 30% cut in physicians’ Medicare reimbursement rate on January 1 unless Congress passed legislation to avert the cut. The Medicare therapy caps exceptions process also expired December 31 and the historic vehicle for extending it is the doc fix.

The House took the initiative to roll these so-called “Medicare extenders” into the “three-pack” bill, that also includes an extension of unemployment benefits and the Social Security payroll tax holiday. Controversy developed over provisions that the bill also included on construction of the Keystone pipeline from Canada. The Senate passed bipartisan compromise legislation that would extend all of these provisions for two months. The House finally voted on and passed the bill in spite of a significant group of House members wanting a resolution for the remainder of the year and other provisions related to paying for these extensions.

The therapy caps exceptions process extension is different this year than it has been in the past in two ways:

- The extension is for two years, which is good. But there are new provisions for increased review of an individual's use of therapy and for MedPAC to study and recommend improvements in the outpatient therapy benefit.
- The bill contains a number of provisions to offset the cost of the exceptions process extension and the doc fix. The one of greatest concern to us would reduce Medicare reimbursement to skilled nursing facilities for bad debt. The provision includes elimination of the exception for Medicaid, allowing reimbursement of only 85% of the state's failure to pay its share of a dually eligible beneficiary's SNF stay in FY 2013, 70% in FY 2014, and 55% subsequently.

Fiscal 2012 spending: Having dispensed with the so-called “minibus” spending bill that included senior housing funding, Congress still has to finalize funding for the remaining agencies and programs, including Older Americans Act programs. The congressional leadership is adamant that the measure will be a comprehensive spending bill rather than a continuing resolution that just keeps federal programs in operation with current funding levels. Continuing resolutions have become sort of a dirty word in recent years because they have facilitated congressional failure to deal with appropriations according to the prescribed timetable.

Since some agencies have already received their appropriations, Congress won't have to call the impending spending bill an omnibus either. Omnibus bills have

almost the taint of continuing resolutions because they similarly demonstrate the inability to carry out the appropriations process in an orderly way. So the bill Congress must complete before leaving town is being referred to as the “megabus”.

For the programs of interest to members, the distinctions among these various kinds of vehicles do not matter greatly. No information is yet available on the spending level to be provided for Older Americans Act programs..

The megabus bill did pass late on Friday, December 16th heading off a potential partial government shutdown. The White House has indicated the President will sign the measure. The Office of Management and Budget has authority to keep the government in operation until these formalities are completed. As of Friday, December 16th, nothing had not seen about funding levels in the bill for activities like Older Americans Act programs and nursing home survey and certification.

A new regulatory issue - Department of Labor Issues Proposed Regulation Limiting Companionship Exemption: The Wage and Hour Division of the Department of Labor (DOL) has released a proposed regulation that would lift the so-called “companionship exemption” for agency-employed, non-medical home care workers that provide companionship and other services for individuals who, because of age or infirmity, are unable to care for themselves. Lifting the exemption would entitle such workers to minimum wage and overtime protections under the Fair Labor Standards Act. The rule would not affect the exempt status of such workers if they are hired directly by the individual or the individual's family or household.

In addition to lifting the exemption for workers hired by an agency, the rule would revise the definition of “domestic service employment” and “companionship services,” and would clarify the type of activities and duties that may be considered incidental to the provision of companionship services. A 60-day comment period will begin upon publication of the proposed rule in the *Federal Register*. <http://www.dol.gov/whd/flsa/CompanionshipNPRM.pdf>

Should You Provide the U.S. Census Bureau with Lists of Residents?

Should you provide U.S. Census Bureau workers with lists of resident names if asked for it? It may feel awkward, but the short answer to the question is, “yes.” This question came up recently – and we got the following response/reminder from the U.S. Department of Housing and Urban Development

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National News

(HUD) and the text of a prior RHIP Listserv posting:

June 15, 2010, RHIP Listserv Posting # 230
2010 Census—What information can be provided to census takers?

Article I, Section 2 of the Constitution of the United States calls for an actual enumeration of the people every ten years to be used for appointment of seats in the House of Representatives among the states. In March 2010, census takers began going to addresses across the country to count the population and to collect information for the 2010 Census.

Census takers are required to contact occupied apartments themselves; however, if an apartment is vacant or if the census taker is unable to contact the tenant, the census taker is instructed to ask an apartment owner/manager to answer a few short questions about the apartment (e.g. who was occupying the unit on April 1, 2010), as well as provide the name and phone number of the apartment owner/manager in the event that the Census Bureau needed to ask any follow-up questions.

In accordance with 13 USC 223 (shown below), owners and/or managers of Multifamily Housing properties must provide census takers with the names of tenants residing in their property when requested by a census taker. If the census taker needs information past the names of the tenants, they should request this information from HUD. Detailed information outside of the law below has to be requested from HUD as outlined in the Federal Privacy Act, as HUD is authorized to provide the detailed information maintained in a system of records (as defined by the Privacy Act). Because there are no Privacy Act implications, owners and/or managers could also provide information on what units were vacant. Property owners/managers are not authorized to disclose additional information.

In addition, Contract Administrators (CA) of HUD Multifamily programs must not provide any tenant information to census takers. If contacted, CAs should refer the census taker to the owner or manager of the property.

§ 223. Refusal, by owners, proprietors, etc., to assist census employees

Whoever, being the owner, proprietor, manager, superintendent, or agent of any hotel, apartment house, boarding or lodging house, tenement, or other building, refuses or willfully neglects, when requested by the Secretary or by any other officer or employee of the Department of Commerce or bureau or agency thereof, acting under the instructions of the Secretary, to furnish the names of the occupants of such premises, or to give free ingress thereto and egress therefrom to any duly accredited representative of such Department or bureau or agency thereof, so as to permit the collection of statistics with respect to any census provided for in subchapters I and II of chapter 5 of this title, or any survey authorized by subchapter IV or V of such chapter insofar as such survey relates to any of the subjects for which censuses are provided by such subchapters I and II, including, when relevant to the census or survey being taken or made,

the proper and correct enumeration of all persons having their usual place of abode in such premises, shall be fined not more than \$500.



How the Recession Impacts Baby Boomer Housing

The current recession is likely to keep many baby boomers from moving to new homes during their retirement, according to a recent Associated Press poll. But an analysis by AARP suggests that staying put may not provide boomers with the financial safety net they need to live comfortably.

More than half (52%) of baby boomers responding to a recent poll conducted by the Associated Press and LifeGoesStrong.com, say they are unlikely to move from their homes in retirement unless it is to buy a smaller home that's more affordable and closer to family. Older boomers are more likely to stay put. Almost half (48%) of this group say that it is extremely or very likely that they will stay in their current homes during retirement, compared with 35% of younger boomers. Those who have lived in their current home for 20 or more years are also more likely to say they won't move.

Financial worries are driving the decisions to stay at home. Only 9% of survey respondents said they are strongly convinced they will be able to live comfortably when they retire. Almost three-quarters (73%) said they will keep working during retirement.

An AARP analysis of data from several sources, including the 2009 American Community Survey, shows that a combination of tightening credit, declining housing price, shrinking home equity, foreclosures, job losses and unemployment has reduced housing stability for older homeowners over the past decade. Fewer older adults can sell their homes, and those homes no longer provide a financial safety net for their owners. Specifically, housing stability for older adults has been eroded by:

- **More mortgages.** Fewer older adults owned their homes outright in 2009 than in the previous decade. In 2000, 40% of homeowners age 50 and older owned their homes free and clear, compared with 38% who had a mortgage. By 2009, those numbers had flipped: 38% of older homeowners were living without a mortgage while 42% were still paying off their homes.
- **More foreclosures.** There were 49,980 foreclosures and 636,003 delinquencies among households age 50 and older at the end of 2007. As the housing crisis worsened, those figures undoubtedly rose much higher, says AARP.
- **More disability.** Rising disability rates are impacting housing security among older adults, according to AARP. In 2009, 42% of renters and 32% of owners aged 50 and older had a disability, compared with 54% of renters and 42% of owners aged 65 and older. Given the fact that people age 50 and older are likely to live in older homes that lack accessibility features, AARP predicts that it will become increasingly difficult for members of the growing older population to find housing that meets their needs.

Smoke Free

CMS released an alert on November 10, 2011, titled *Smoking Safety in Long Term Care Facilities*, which includes the following summarized recommendations:

- Designate safe smoking areas which include protection of smoking residents from inclement weather, and protection of non-smokers from second hand smoke. Each smoking area must include safe, non-combustible ashtrays and metal containers with self-closing covers into which the ashtrays can be emptied. Portable fire extinguishers must be available.
- Allow smoking only in designated areas.
- Prohibit oxygen use in smoking areas.
- Assess each smoking resident's capabilities and deficits to determine if supervision is required. If a resident is deemed capable of independent smoking, document this in the care plan and other designated locations so staff knows the correct procedure for each resident. Keep this information current, and update it if the resident's capabilities and needs change. Error on the side of caution when unsure if the person can be designated as a safe smoker.
- Supervise residents whose assessment and plans of care indicate a need for supervised smoking.
- Revise facility policies to describe the methods by which residents are deemed safe to smoke without supervision, including review of their cognitive abilities, judgment, manual dexterity and mobility.
- Be ready to provide surveyors with documentation of the assessment that resulted in a resident being permitted to smoke without supervision.
- Inform visitors of smoking policies and hazards and enlist their help in preventing smoking incidents.
- Electronic cigarettes are not considered smoking devices, and their heating element does not pose the same dangers as regular cigarettes.

For more information on this topic, you can obtain the full CMS memo from http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter12_04.pdf

Countering Incentive of Unnecessary Hospitalizations

Many nursing home residents are hospitalized for changes in status that could be treated outside of the hospital, evidence suggests. Unnecessary hospitalizations are costly and can lead to adverse outcomes, according to Joseph G Ouslander, MD and Robert A. Berenson, MD.

A number of factors contribute to the high incidence of avoidable hospitalizations with nursing home residents. One of these factors is discrepancies between Medicare and Medicaid reimbursement. Providing "in-house" treatment to a nursing home resident with Medicaid coverage, the author noted, can be a "lose-lose" proposition. "Medicaid programs do not benefit from savings that Medicare accrues from prevented hospitalization of nursing home residents." explains the author. Making matters worse, current payment policy can actually create an incentive for nursing homes to hospitalize residents with a change in status. If they do and the resident has an inpatient stay of 3 or more days, he or she may be eligible for Medicare Part A coverage for post-acute care in the nursing facility "at 3 to 4 times the daily rate paid by Medicaid."

The Affordable Care Act (ACA) calls for the development and testing of additional payment approaches to eliminate financial impediments to providing appropriate care to Medicare and Medicaid beneficiaries.

Incentives to reduce unnecessary hospitalizations of nursing home residents should

(continued on the back)

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Nurse's Notes

focus on facilities that have the necessary expertise, staff, infrastructure, and culture of quality to do the job right. Facilities that are not well-prepared should get the assistance they need to improve and demonstrate that they've done so, in order to qualify for additional funding for lowering hospitalization rates.

"We can improve care and reduce preventable hospitalizations of nursing home residents," the authors conclude, "but it will require a multifaceted approach; commitment of energy and resources; teamwork among healthcare professionals, nursing homes and hospitals; and a true focus on resident centered care.

(Annals of Long term Care. November 2011 <http://www.annalsoflongtermcare.com/article/countering-incentives-unnecessary-hospitalizations>)

Non-drug Interventions as Effective as Medication

A study piloted in German nursing homes proved that non-drug dementia interventions are as effective as medications in halting progression of disease. Dementia resident in 5 Bavarian nursing homes were followed by scientists for 12 months. Half of the residents received the facility's standard treatment and half received those treatments plus a new intervention program.

Researchers after a year compared participants in the test and control groups using the Alzheimer's disease Assessment Scale. It was found that for Residents with mild to moderate dementia, the non-medication therapy was "at least as good as treatment with cholinesterase inhibitors." Researchers said, the effect of the therapy on Erlanger's Test of Daily Living was "Twice as High" as the results achieved by medication.

Called the "MAKS intervention," this new program included motor stimulation activities (M); activities of daily living, such as gardening and crafting (A); cognitive stimulation via group and individual puzzles

(K); and a "spiritual element," (S) which included singing hymns and discussing topics such as happiness. The therapy in the nursing home was offered for 2 hours per day, six days a week.

"MAKS therapy is able to extend the quality of and participation in life for people with dementia within a nursing home environment," said Prof. Elmar Graessel lead researcher.

(McKnights.com http://www.mcknights.com/dementia-researchers-find-non-drug-intervention-at-least-as-effective-as-medications-in-halting-disease-progression/article/218067/?DCMP=EMC-MCK_Daily)



More Research and Better Diagnostic Needed

Delirium, which is defined as a sudden alteration of mental status and severe confusion, is unrecognized in 60% of patients who experience, according to researchers at Indiana University School of Medicine. The condition is known to be a predictor of decreased lifespan and increased healthcare costs. Delirium is not the same thing as dementia, but individuals with dementia are more likely to develop delirium while hospitalized than patients without dementia.

"Having delirium prolongs the length of a hospital stay, increases the risk of post-hospitalization transfer to nursing homes, doubles the risk of death, and may lead to permanent brain damage." IU researcher Malaz Boustani, MD said. "We need to identify those who have delirium and to develop safe and effective ways to prevent and treat delirium."

(McKnights.com http://www.mcknights.com/more-research-and-better-diagnostics-are-needed-to-treat-delirium-researchers-say/article/217183/?DCMP=EMC-MCK_Daily)

Part B Payment Snafu for SNFs

Nursing home members should note the following announcement from CMS:

A claims processing issue was identified that has affected payment of some Part B claims for SNF patients for **dates of service from Saturday, Oct. 1, 2011 through Monday, Nov. 21, 2011**. Some Part B claims for SNF patients submitted to Medicare during October and November 2011 have been erroneously denied by Medicare's claims processing system. In other instances, the claims processing system has paid and then identified a Medicare "overpayment" on these claims in error.

If you submitted a Part B claim for a SNF patient, you may receive a system-generated Demand Letter from Medicare, or you may see a notification for a payment offset on your Remittance Advice.

Your Medicare Claims Administration Contractor is working with CMS to remedy this problem in the claims processing system so that appropriate payment adjustments can be made. CMS is asking providers not to appeal these claims at this time. Because these are erroneous adjustments in Medicare's claims processing system, submitting an appeal may slow down the correct adjustment of your claim.

Your Medicare Claims Administration Contractor will notify you when the adjustment process for these claims is initiated and keep you updated so that you can anticipate when your claims (along with any notifications for payment recovery) will be adjusted.

CMS Issues Update to the Independent IDR Process

On Dec. 2, the Centers for Medicare and Medicaid Services (CMS) issued a new survey and certification letter updating the guidance to state agencies on the development and implementation of the Independent Informal Dispute Resolution (IIDR). http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter12_08.pdf

The IIDR, applicable to all standard and complaint surveys begun on or after Jan. 1, 2012, must be offered to nursing homes when a civil money penalty (CMP) is imposed and the funds are subject to collection and placement in an escrow account. Revisit surveys conducted on or after January 1 that are associated with standard or complaint surveys completed before that date will not be subject to the IIDR process even if a CMP is imposed after January 1.

The letter, Federal Requirements for the Independent Informal Dispute Resolution (Independent IDR) Process for Nursing Homes – Interim Advance Guidance, replaces the previous CMS letter of Oct. 14, and further clarifies the applicability and Key Elements of the IIDR process.

ISDH has a draft of the procedure to implement the IIDR process, however it is not available for release at this time. However, CMS provides the interim advanced guidance to be included in the State Operations Manual (SOM) regarding the Federal requirements for the IIDR.

What's in the Letter:

- Section 611 of the Patient Protection and Affordable Care Act (ACA) of 2010 provides facilities with the opportunity for an IIDR when a CMP is imposed and the funds are subject to being collected and placed in an escrow account, i.e., the IIDR "...must be offered to nursing homes for deficiencies that lead to the imposition of a civil money penalty (CMP) and for which notice has been provided to the nursing home that the CMP will be collected and placed in escrow."
- The Federal requirements for IIDR will apply to all standard and/or complaint surveys begun on or after January 1, 2012 that initiate an enforcement action for which a civil money penalty (CMP) is imposed and is subject to being placed in escrow.
- Any revisit survey conducted on or after January 1, 2012, that is associated with standard or complaint surveys completed before January 1, 2012 will not be subject to the IIDR process even if a CMP is imposed after January 1, 2012.
- The letter includes interim advanced guidance to be included in the State Operations Manual (SOM) regarding the Federal requirements for the IIDR.
- States may not charge facilities for the IIDR. Costs incurred by State Agencies (SAs) for conducting IIDRs are eligible for federal funding using existing/standard cost allocation principles. In situations where the IIDR process is not required, but is provided by the State directly at its option, the State may choose to charge a facility a user fee for those processes.

Advanced SOM Guidance - 7313.1 – 7213.11

- A SA does not need to create any new or additional processes for IIDR if its existing process meets the requirements at 42 CFR 488.331 and 488.431 and described throughout §7213.
- An opportunity for IIDR must be provided within 30 calendar days of the notice of imposition of a CMP that is subject to collection and placement in escrow.
- IIDRs will –
 - Be completed within 60 calendar days of a facility's request, if requested timely.
 - Generate a written record prior to the collection of the penalty;
 - Include notification to an involved resident or resident representative, as well as the State's long term care ombudsman, to provide opportunity for written comment;
 - Be approved by CMS and conducted by the State or an entity approved by the State and CMS, or by CMS or its agent in the case of surveys conducted only by Federal surveyors where the State IIDR process is not used, and which has no conflict of interest, such as:
 - * A component of an umbrella State Agency provided the component is organizationally separate from the SA, or
 - * An independent entity with a specific understanding of Medicare and Medicaid

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CMS NEWS

program requirements selected by the State and approved by CMS, and,

- * Not include survey findings that have already been the subject of an IDR for the particular deficiency citations at issue in the IIDR, unless the IDR was completed prior to the imposition of the CMP.
- The IIDR, as established by the SA and approved by CMS must be in writing and available for review upon request. If an IIDR entity provides services in multiple States and/or CMS Regions, each State and its CMS Regional Office (RO) must approve the process and procedures.
- Each SA must submit its written process and procedures, including subsequent changes, to the CMS RO for review and prior approval.
- Beginning January 1, 2012, CMS may collect and place imposed CMPs in an escrow account on whichever of the following occurs first:
 - The date the IIDR process is completed, or
 - 90 calendar days after the date of the notice of imposition of the CMP.
 - The IIDR is conducted upon the facility's request, i.e., within 10 calendar days of receipt of the offer.
 - To phase in the CMP collection and escrow provisions, CMS initially intends to collect and escrow "...only those penalties imposed as a result of the most serious deficiencies." Beginning January 1, 2012, and until further notice, only CMPs imposed for a deficiency or deficiencies cited for actual harm or immediate jeopardy (i.e., level of G or above) will be subject to the CMP collection and escrow provisions and IIDR.
 - For deficiencies less than G (i.e., D, E, and F), CMPs imposed will continue to be collected under the current IDR process without a requirement for IIDR.
- A facility may request IIDR for each survey that cites deficiencies at G or above for which a CMP has been imposed and will be collected and placed in escrow. However, the facility cannot raise questions or issues regarding a previous survey.
- The IIDR process does not delay the imposition of any remedies, including a CMP.
- A facility may dispute the factual basis of the cited deficiencies for which it requested IIDR, but may not challenge other aspects, such as:
 - Scope or severity, with the exception substandard quality of care or immediate jeopardy;
 - Remedy(ies) imposed;
 - Alleged failure of the survey team to comply with a requirement of the survey process;
 - Alleged inconsistency of the survey team in citing deficiencies among other facilities;
 - Alleged inadequacy or inaccuracy of the IDR or IIDR process.
- While States have discretion to limit participation by attorneys or other parties, notice to facilities should indicate that IIDR constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing.
- The IIDR process provides recommendations to the State and CMS and are not subject to appeal.
- The documents and written report created by the IIDR entity, the State and CMS, other than the final decision, are pre-decisional and deliberative, and are therefore protected from disclosure under the deliberative process privilege.
- At a minimum, IIDR must provide the following:
 - Opportunity for IIDR within 30 calendar days of CMS's notice of imposition of a CMP that will be collected and placed in an

escrow account. The CMS RO will communicate the offer in its initial Notice of Imposition of a Penalty letter to a facility.

- The notice will provide SA contact information, including the person, agency, or office the facility must contact to request IIDR.
- The Notice of Imposition of a Penalty letter must be sent to the facility by certified mail return receipt requested and may also be sent by e-mail and/or fax. The Statement of Deficiencies (Form CMS-2567) may be included. A copy will also be sent to the SA.
- Upon a facility's timely request, the SA or IIDR entity will provide the following information:
 - Information on the IIDR process including where, when and how the process may be accomplished, e.g., by telephone, in writing, or a face-to-face meeting, and
 - Contact information, including the name, address, phone number and e-mail of the person(s) who will conduct the IIDR, if known.
- As with the current IDR process, the Independent IDR process will be available to a facility at no charge.
 - Collected CMP funds may not be used to cover State expenses for IDR or IIDR. A portion of collected CMP funds may be used for activities that protect or improve quality of care for residents.
- The facility must request IIDR, in writing, within 10 calendar days of receipt of the offer. Requests must include copies of any documents or other information, redacted to protect resident confidentiality, on which it relies in disputing the survey findings.
- IIDR must be completed within 60 days of the facility's request. However, failure to comply with the IIDR process does not invalidate any deficiencies or remedies imposed.
- The IIDR process is completed no later than 60 calendar days from receipt of the request. IIDR is considered completed if a facility does not timely request or chooses not to do so, or when a final decision has been made, a written record generated, AND the SA has sent the facility written notice of the final decision.
- Once a facility requests IIDR, the SA must notify the involved resident or resident representative, and long term care ombudsman of their opportunity to submit written comment.
- At a minimum, the notification must include:
 - A brief description of the noncompliance and reference to the survey date;
 - Information on when, where, and how comments must be submitted;
 - A designated contact person to answer questions/concerns;
 - Contact information for the State's long term care Ombudsman.
- The IIDR entity must generate a written record no later than 10 calendar days of completing its review.
- The written record shall include:
 - A list of each disputed deficiency or survey finding;
 - A summary of the IIDR recommendation for each deficiency or finding and the rationale;
 - Documents submitted by the facility;
 - Any comments submitted.
- Upon receipt of the IIDR written record, the SA will review the recommendation(s) and:
 - If the SA agrees and no changes will be made to the disputed survey findings, the SA will send written notifi-

cation of the final decision to the facility within 10 calendar days from receipt of the written record.

- If the SA disagrees with one or more of the recommendations, the complete written record will be sent to the CMS RO for review and final decision.
- No later than 10 calendar days, the CMS RO will provide written notification to the SA of the final decision. The SA will send written notification of the final decision to the facility within 10 calendar days from receipt of the final decision.
- If the SA agrees with the recommendation(s) or has received a final decision from the CMS RO and changes will need to be made, the SA will provide written notification of the results and final decision to the facility within 10 calendar days from receipt of the written record and will:
 - Change deficiency(ies) citation content findings, as recommended.
 - Adjust the scope and severity assessment for deficiencies, if warranted by CMS policy;
 - Annotate deficiency(ies) citations as “deleted as recommended.”
 - A SA manager or supervisor will sign and date the revised CMS Form-2567.
 - The SA will promptly recommend to CMS that any enforcement action(s) imposed solely because of deleted or altered deficiency citations be reviewed, changed or rescinded.
- Any Form CMS-2567 and/or plan of correction that is revised as a result of IIDR must be disclosed to the State long term care ombudsman.
- Deficiencies pending IDR or IIDR will not be used to calculate the 5-Star score, posted to Nursing Home Compare, or available for public reporting until the IDR and/or IIDR is fully processed and successfully uploaded to the national repository.
- To be approved as an IIDR entity:
 - The entity must have an understanding of Medicare and Medicaid program requirements including, but not limited to:
 - a) 42 CFR Part 483, Subpart B, and Part 488, Subparts A, E and F;
 - b) The State Operations Manual (SOM), including:
 - 1) Chapter 7, Definitions and §§ 7212, 7213 and 7900;
 - 2) Appendix P, Appendix PP, Appendix Q;
- Applicable standards of practice, health care management, and/or life safety code knowledge and experience, relevant to the disputed issues.
- The IIDR entity –
 - Has no financial or other conflict of interest;
 - May be a component of an umbrella State agency provided the component is organizationally separate from the SA;
 - May be an independent entity with an understanding of specific Medicare and Medicaid program requirements selected by the State and approved by CMS.
- The CMS RO will review and approve all written policies and procedures of the State’s IIDR process.
- The SA and IIDR entity must enter into a written contract or Memorandum of Understanding (MOU) ensuring compliance with all qualifications and responsibilities set forth and all applicable Federal laws and regulations concerning protected health information and the survey process or the IIDR.

- An IIDR entity must not disclose to the public any information related to the facility, including the results of the IIDR review.

New CMS S&C Letter on Budget Reductions

Prudent Action for the FY 2012 Medicare Survey & Certification (S&C) Budget (12/09/2011)

http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter12_12.pdf

This memo is issued by CMS in anticipation of reductions in budget levels for FY2012: “While Congress has not yet acted on legislation to fund CMS for FY2012 CMS, early indications are that the budget level for Medicare survey & certification (S&C) will most likely be 10%-12% less than the level requested by the President. Therefore, [CMS] believes “..it is prudent to prepare now for a lower FY2012 funding level than previously expected...”

- CMS will expand the Agency’s efficiency initiatives (see section D below); strictly enforce CMS S&C policies, and reduce or delay certain CMS activities, e.g., slowing down the rate at which States are added to the QIS; extending the timeline for electronic collection of nursing home staffing data.
- CMS will continue to fulfill “...statutorily-required surveys (nursing homes and home health agencies) as the top priority for onsite surveys, and will sustain recent survey improvements for other providers (e.g., better surveillance of infection control lapses among provider types).”
- CMS reiterates its policy regarding initial surveys for Medicare certification, i.e., that statutorily-required surveys, targeted surveys of poorly-performing providers, and complaint investigations take precedence over initial surveys.
 - Among initial surveys, priority is given to provider types (e.g., ESRD facilities, nursing homes, and transplant centers) that do not have a Medicare deemed status option.
 - CMS will continue to consider exceptions to the tiered priorities for initial surveys if there are serious access-to-care issues.
- CMS advises funding for States, i.e., a reduction for FY2012; maintenance of FY2011 funding levels; or an increase for Medicare S&C, based on assessment of each State’s “... needed resources, recent performance, and CMS’ analysis of the probability that States will reach performance goals and effectively use funds in light of State budget constraints, personnel decisions regarding furloughs, hiring freezes, etc...”
- CMS Regional Offices (ROs) will conduct State reviews, to include current prospects for:
 - Filling vacancies, and the extent that furloughs and hiring limits are in force for S&C activities;
 - Training plans and capabilities, particularly for new and existing surveyors to obtain necessary CMS training face-to-face and online;
 - Completing the CMS workload in accordance with CMS priorities.
- CMS expects to have the review process completed by 12/22/11, with RO recommendations for FY2012 funding levels. CMS will issue revised Medicare S&C funding amounts in 1/12.
- States are to submit a Medicare budget based on the revised projections by 2/28/12, to include contingency plans for prioritized tasks should final allocations be lower or higher

(by 2.5%) than CMS' revised targets.

Efficiency + Effectiveness Initiatives

CMS will apply the following principles:

- **“Reduce lower value activities in favor of higher value: Reduce surveyor time spent on lower value areas in favor of more attention to higher value or higher risk areas.**
- **Strengthen Incentives and Enforcement:** Strengthen incentives and enforcement for providers to improve quality, and to reduce repetition of problems by the same providers.
- **Use Performance Data to Target Attention to Higher Risk Areas:** Increasingly use survey information, claims data, complaint information, quality indicators, and other data to improve the ability to direct surveyor attention. Provide increased information and transparency to consumers in user-friendly formats to engender more user and provider attention to quality of care and safety.
- **Target Technical Assistance to Poorly-Performing Providers:** Increasingly seek to coordinate with sources of technical assistance (such as the Quality Improvement Organizations (QIOs), ESRD networks, educational institutions, Advancing Excellence, and others) so that technical assistance can be more available to persistently poorly-performing providers.
- **Place a Top Priority on State Onsite Surveys:** Objective, onsite surveys conducted by trained State and Federal surveyors (including onsite investigations of serious complaints by the public, beneficiaries and others) remains a top CMS priority.”

CMS-identified actions for immediate implementation or [near] future consideration:

- Immediate Action Examples:
 - **(a) IPPS-Excluded Existing Hospitals:** States will no longer conduct onsite re-verification of IPPS exclusion criteria for a 5% sample. These sampled surveys will be suspended indefinitely.
 - **(b) QIS Expansion:** CMS will extend the timeline for adding new States to the QIS for nursing homes. A separate communication will provide details on the revised schedule.
 - **(c) Government Accountability Organization (GAO) and Office of the Inspector General (OIG) Recommendations:** CMS is deferring to FY2013 - FY 2014 many GAO and OIG recommendations scheduled for action in FY2012. A revised schedule will be issued.
- CMS will continue to advance in FY2012:
 - **(d) ASC Infection Control Worksheets:** As of 1/1/12, SAs will no longer submit a completed ASC infection control worksheet to CMS' contractor (Acumen). SAs will continue to use the worksheet to guide assessment of an ASC's compliance with infection control requirements. CMS will continue to maintain a survey frequency of once every 4 years.
 - **(e) ESRD Surveys:** CMS is expanding the tier III maximum time interval between surveys to once every 4 years, from once every 3.5 years.
 - **(f) Hospice:** CMS is expanding the tier III maximum time interval between surveys to once every 7 years from once every 6.5 years; retaining as a high (tier II) priority the survey of a 5% sample of the lowest-performing providers.
 - **(g) Transplant Centers:** CMS is expanding the tier III maximum survey interval for surveys to once every 5 years from once every 4 years.
 - **(h) Nursing Home Staffing Data:** CMS is extending the

timeline for design and implementation of a system for quarterly, electronic collection of staffing information in nursing homes as called for in Section 6106 of the Affordable Care Act (ACA). CMS will continue working on design, but not meet the ACA target date, March 23, 2012.

Additional Steps under Consideration:

- **Nursing Homes:** CMS is exploring methods to increase the focus on certain high priority areas via greater 'efficiencies' in other areas:
 - **Poorly-Performing Nursing Homes (PPFs):** Potential expansion of the SFF initiative; coordination with other entities (such as QIOs) to provide increased technical assistance to PPFs serving high proportions of low-income recipients or nursing homes in areas with access-to-care problems; focus CMS validation surveys on facilities rated lower in quality (e.g., the one, two or three-stars); no longer require the LSC survey for the 6th-month SFF survey.
 - **Inappropriate Use of Anti-Psychotics:** CMS is exploring methods to design and implement a program to reduce inappropriate use of medications, particularly anti-psychotics; and include new quality measures for posting on the NH Compare website.
 - **Avoidable Falls:** A new measure and effort to reduce avoidable falls.
 - **Life-Safety Code (LSC) Evidence:** Potential reduction in required onsite surveyor time, e.g., increased documentation and attestation by nursing homes to provide evidence of regular maintenance checks, fire drills, emergency preparedness, etc.; distinguishing LSC requirements under: (a) structural, such as 1-hour fire walls and smoke compartments, and (b) maintenance, extending the time period for the engineer's LSC survey and adding checks to the health portion of the annual survey to address expectations for continuous maintenance.
 - **Higher-Performing Facilities:** Potential reduction in required survey time for five-star facilities, with the exception that serious complaints or findings would trigger the longer survey.
 - **Hospitals:** Retaining support of CMS' Partnership for Patients initiative via focused surveys for infection control, discharge planning, and QAPI; potential alternative methods for targeting complaint and full surveys for accredited hospitals, e.g., surveys based on an assessment of risk, as currently conducted for non-accredited hospitals for condition-level noncompliance; increased communication and coordination with accrediting organizations (AOs), regarding complaint investigation surveys for accredited hospitals.
 - **Dialysis Facilities:** Potential application of a basic survey to facilities with performance data in the top 33%-50%.
 - **National Training Institute:** Consideration of methods to maintain momentum for the design and implementation of a national training institute for training surveyors in complaint investigations.

CMS invites comments and suggestions regarding potential methods to increase the efficiency and/or effectiveness of survey and certification functions. Suggestions and comments may be sent to BetterCare@cms.hhs.gov.

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