Tried and True Tips for Improved Documentation and Successful Appeals

Marjorie Mantione, PT
Clinical Implementation Specialist
Appeal Specialist
Uniform Data System for Medical Rehabilitation

Angela Cannon, RN, BSN
Clinical Appeals Coordinator
Clinical Appeals Specialist
Uniform Data System for Medical Rehabilitation

Agenda

• Review RAC IRF denials examples
  • Documentation denials
  • Technical denials
• Recommendations to overcome denials
• Supporting information for letters of appeal

Reason 1: Reasonable and Necessary Criteria

• “Review does not find that admission to the IRF level of care was reasonable and necessary.”
• “Documentation does not support that the patient’s medical management and rehabilitation needs required an inpatient stay.”
• “None of the medical issues on admission justified an acute level of care.”
Reason 1: Reasonable and Necessary Criteria

- **Recommendations:**
  - Documentation must clearly identify and strongly support the patient’s medical and functional deficits
  - Pre-admission assessment
  - Post-admission physician evaluation (PAPE)
  - Documentation must explain why the patient’s deficits warrant care in an IRF with the supervision of a rehabilitation physician and an interdisciplinary team approach to care

Denial Rationale

- “It is the determination of our audit team that the Pre-Admission Assessment speaks directly to the medical necessity for IRF admission.”

Reason 1: Reasonable and Necessary Criteria

- The nine required elements of a pre-admission assessment should be easily identifiable:
  1. Prior level of function
  2. Expected level of improvement
  3. Expected length of stay
  4. Evaluation of patient’s clinical risks for complications
  5. The condition that caused the need for inpatient rehabilitation
  6. The combinations of treatments (PT, OT, ST, prosthetics, orthotics)
  7. Expected frequency and duration of treatments
  8. Anticipated discharge destination
  9. Anticipated post-discharge treatments
Reason 1: Reasonable and Necessary Criteria

• Recommendations:
  • The PAPE must document the patient’s status at admission to the IRF, compare it to the patient’s pre-admission status, and begin developing the expected course of treatment
  • Capture any complications that occurred while the patient was in acute care, such as post-surgical acute blood loss, anemia requiring transfusion, abnormal electrolytes, respiratory distress, etc.
    • Acute care complications often necessitate ongoing evaluation and intervention from a rehabilitation physician in an IRF setting

Reason 2: Documented Comorbidities

• “The comorbidities documented are past or chronic conditions which would not necessitate supervision in the IRF by a physician with specialized training and expertise in rehabilitation.”

Reason 2: Documented Comorbidities

• Recommendations:
  • Comorbidity documentation should reflect the impact on the patient’s current status
  • For example:
    • How cardiac conditions and hypertension can be exacerbated by (1) demand of increased activity level or (2) pain
    • The importance of ongoing laboratory studies for patients with post-hemorrhagic anemia to evaluate hemoglobin and hematocrit levels to ensure that levels do not drop and require transfusion or cause tachycardia, weakness, and fainting
Reason 2: Documented Comorbidities

- **Recommendations:**
  - Medical conditions must be tied to functional deficits
  - The physician’s documentation must illustrate ongoing medical and functional evaluation, interventions to address barriers, and progress attained through interventions

Reason 3: Intensive and Multidisciplinary Therapy Services

- **Recommendations:**
  - The rehabilitation physician must identify the necessary treatments and the expected course of treatment in the pre-admission assessment and the PAPE
  - Interdisciplinary goals should be supported in the synthesis of the IOPOC
  - Therapists and rehabilitation nurses should support the complexity of the patient’s care by providing daily notes and shift assessments that illustrate interdisciplinary communication
Reason 4: Medical Medication Management

- “The patient was on oral medications for pain and the patient’s other listed co-morbidities are not requiring need for medication management at an IRF level of care.”

- Justify rehabilitation nursing medication interventions
- Justify the rehabilitation physician’s medication protocol development and need to evaluate the effects of one medication on another and on other comorbidities
- For example:
  - Explain the rehabilitation nursing interventions required for sliding-scale insulin coverage
  - Explain the patient’s need for a rehabilitation physician’s evaluation when the patient needs narcotics for pain but is battling constipation

Reason 5: Joint Replacements

- Denials related to a “unilateral single affected joint” or “knee and hip replacements”
Reason 5: Joint Replacements

• Recommendations:
  • Unilateral joint afflictions:
    • Documentation should emphasize comorbidities that contribute to the functional deficits related to the affliction
    • Documentation should illustrate the effects of coordination and balance deficits on the patient’s ability to progress with therapy skill sets
    • Documentation should demonstrate the patient’s need for interdisciplinary care to achieve goals related to returning to the patient’s prior level of function

Reason 5: Joint Replacements

• Recommendations:
  • Emphasize the necessity of inpatient rehabilitation admission for these patients, as referenced in Transmittal 938
    • Did the patient have a bilateral replacement?
    • Does the patient have a BMI of 50 or greater?
    • Is the patient eighty-five years old or older?

Reason 6: Skilled Interventions

• “Documentation does not indicate that therapy services provided were of a skilled nature and services did not require treatment by a skilled therapist.”
Reason 6: Skilled Interventions

- **Recommendations:**
  - Therapy evaluations must illustrate skilled assessments
  - Daily therapy progress notes must illustrate the provision of skilled treatments
  - Documentation must support the complexity of care expected in the IRF environment

Reason 6: Skilled Interventions

- **Recommendations:**
  - Documentation must identify goals, illustrate the patient’s progress towards goals, and provide evidence that the goals were revised if necessary to achieve optimal functional outcomes
  - Documentation must illustrate working toward individualized functional skills related to the patient’s home environment

Reason 7: Pre-admission Time Frames and Content

- “The Pre-Admission Assessment was not conducted and approved within the 48 hours prior to IRF admission. The Pre-Admission Assessment must be completed by a licensed or certified clinician within the required timeframes and then must be reviewed and concurred with by a rehabilitation physician within the required timeframes and include signature, date and time.”

- “Documentation does not support that the Pre-Admission Assessment was completed as required and contained required elements.”
Reason 7: Pre-admission Time Frames and Content

- **Recommendations:**
  - Utilize forms, whether paper or electronic, that contain and address the nine required elements of a pre-admission assessment
  - The form must be completed by a licensed or certified clinician within the required time frames
  - The rehabilitation physician must review the pre-admission assessment, document his agreement with the IRF admission; and sign, date, and time the document within the forty-eight hours prior to the patient’s admission to the IRF

Reason 7: Pre-admission Time Frames and Content

- **Recommendations:**
  - If a rehabilitation physician performs a pre-admission consult that constitutes a pre-admission assessment, ensure that the consult contains the nine elements required by CMS
  - If this is a facility practice and records are requested for an audit, clearly label the document and refer to its intended purpose

Reason 7: Pre-admission Time Frames and Content

- **Recommendations:**
  - If more than forty-eight hours have passed since the pre-admission assessment, provide an update of the patient’s status
  - Medical and functional information must be updated to reflect the most current and complete status of the patient within forty-eight hours of admission by the appropriate IRF personnel, and any changes from the first screening must be described in detail
  - Documentation must reflect a review of this information and indicate the rehabilitation physician’s agreement with the findings and results to justify the patient’s admission
Reason 8: Post-admission Physician Evaluation (PAPE) Time Frame/Content
• “The PAPE was not conducted within 24 hours of the patient’s IRF admission.”
• “Documentation does not support that the PAPE was completed as required. It was found to be missing key elements.”

• Recommendations:
  • Establish a process for ensuring that this time frame is met and that the PAPE contains the required elements
  • If using an electronic system or transcription notes, ensure that they accurately represent the timing of the PAPE
  • Ensure that required elements are present in the document—denials have been issued when a PAPE does not contain functional information, does not compare the patient’s admission and pre-admission statuses, and does not explain the patient’s expected course of treatment

Reason 9: Individualized Overall Plan of Care (IOPOC)
• “The Individualized Overall Plan of Care (IOPOC) was not completed by day 4 of the patient’s stay.”
• “Documentation does not support that the plan of care included the expected intensity, frequency and duration of anticipated interventions.”
• “Documentation does not support that the IOPOC detailed medical prognosis, anticipated interventions, functional outcomes and discharge destination.”
Reason 9: Individualized Overall Plan of Care (IOPOC)

- Recommendations:
  - Direct discipline clinicians to complete their admission assessments and to contribute immediately to the IOPOC
  - Develop a process for notifying the rehabilitation physician that the document is ready for the physician’s synthesis by the fourth day of the patient’s stay
  - Use a freestanding IOPOC document, and label it clearly

Reason 10: Team Conference

- “Documentation does not support that the patient required and/or received an interdisciplinary team approach to delivery of care.”
- “Documentation does not support that the required team members were present at the team conferences.”

- Recommendations:
  - Documentation must illustrate the contributions of the rehabilitation physician and discipline representatives to the team conference
  - Members of each discipline who treated the patient or have current knowledge of the patient must document their participation in the conference
    - Required disciplines: rehabilitation physician, RN, PT, OT, SLP (if active on case), SW/CM
    - LPNs, PTAs, and COTAs may attend, but they do not meet the criteria for discipline representation at the meeting
**Additional Denial Rationales**

- “Lack of signature, date and time on admission orders”
- “Missing prognosis from the IOPOC document.”
- “MD notes do not reflect medical and functional components”
- “3 hour rule intensity not met”
- “No documented evidence of 3 rehabilitation physician face to face visits per week”
- “Documentation does not support that the IRF PAI corresponds with the patient’s medical record.”

**Keys to Avoiding Denials**

**Accuracy, timeliness, and adherence to CMS’s criteria**
- Detail the medical and functional deficits impacting the patient’s need for an IRF admission
- Ensure that all required documents are completed within CMS’s regulated time frames
- Adhere to the criteria identified in the Medicare Benefit Policy Manual (MBPM)

**Keys to Avoiding Denials**

- Organize each medical record for review
  - Auditors will not spend time organizing and hunting through your records
  - Label all required documents
  - Clearly identify the required elements in each document
Keys to Avoiding Denials

• Content must be clear, legible, and identifiable
  • Paper documentation:
    • Handwriting must be legible for all readers
  • Electronic system:
    • Setup and print formats vary from one electronic system to another
    • Electronic documentation may need to be organized in a reader-friendly format
  • Typed transcription notes:
    • Ensure that the evaluation time is accurate

Tips for Deterring Denials

• Perform internal chart audits on physician documentation, therapy and nursing documentation, SW documentation, weekly team conference meetings, the IRF-PAI, FIM® documentation, and deadlines
• Remember that the patient’s risks for complications must indicate the need for ongoing evaluation, assessment, and IRF intervention
  • Specifying and elaborating on these risks makes the case for the medical necessity of the patient’s admission to the IRF

So Why Do We Have Denials Even When We Do These Things?
Why Do We Still Have Denials?

- Many reviewers do not have IRF experience
- MACs and RACs are not held accountable for their incorrect decisions
- Reviewers are not using risks to determine medical necessity
- Data mining
- “HCFA 13” overlooked by reviewers
- Denying an entire stay for “technical” reasons—even the lack of the term “prognosis”

Really?

- In 2009 and 2010, CMS said it would not necessarily deny cases in early 2010 due to “technicals”

Automated vs. Complex?

- Through the first quarter of 2013, 96% of denied dollars for participating hospitals were for complex denials

Education, Please!

- 59% of respondents indicated they have yet to receive any education related to avoiding payment errors from CMS or its contractors.

The Cost of Defending Denials

- 63% of all hospitals reported spending more than $10,000 managing the RAC process during the first quarter of 2013
- 46% spent more than $25,000
- 10% spent over $100,000

Need New Diagnostic Equipment?

- The value of appealed claims is approaching $1.1 billion dollars
- On average, hospitals report appealing 226 claims to date
### RAC Results: January–March 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Overpayments Collected</th>
<th>Overpayments Returned</th>
<th>Total Quarterly Corrections</th>
<th>FY-to-Date Corrections</th>
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<tr>
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<td>$1.2</td>
<td>$107.6</td>
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<tr>
<td>Region C</td>
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<td>$10.4</td>
<td>$201.0</td>
<td>$456.4</td>
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<tr>
<td>Region D</td>
<td>$218.2</td>
<td>$8.0</td>
<td>$226.2</td>
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<td>Nation</td>
<td>$626.5</td>
<td>$31.0</td>
<td>$657.5</td>
<td>$1,436.7</td>
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All figures in millions of dollars. Nationwide figures rounded, based on actual collections.

### Are We Making Progress?

- Three-fourths of all appealed claims are still sitting in the appeals process  
  — *Source: AHA. (April 2013). RAC TRAC Survey.*

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### Are We Making Progress?

- Of the claims that have completed the appeals process, 72% were overturned in favor of the provider
  - Regions A and B (Performant and CGI) have the highest overturn rate upon appeal  
  — *Source: AHA. (April 2013). RAC TRAC Survey.*

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Are We Making Progress?

- Hospitals reported a total of $157.2 million in overturned denials, with $44.1 million in Region C alone (Connolly)


The News from the Recovery Auditor

“This is to inform you that you have received a Medicare payment in error which has resulted in an overpayment subject to the 935, Limitation on Recoupment in the amount of $_________ dollars”

Rebuttal

- This is an opportunity to provide a statement and evidence indicating why the overpayment action will cause a financial hardship and should not take place
- A rebuttal is not intended to review supporting medical documentation or disagree with the overpayment decision
- A rebuttal is not an appeal/redetermination request
- A rebuttal does not stop the clock from ticking
Discussion Period

- This is the time from the initial determination to the time funds are recouped or the RAC withdraws the claim and changes its determination
- Forms for “discussion” are provided on the RAC websites
- The day the N432 code appears on the remittance advice is the first day of the appeals process, which should match the date of the demand letter
- If you are having a “discussion” with the RAC and receive a demand letter, the clock does not stop due to the discussion

Prove the Value: Appeal

Use Knowledge and Experience to Disprove the Reviewer’s Allegations

Don’t Lose Time Waiting for Demand Letters!

- If a facility receives unfavorable review sheets from the recovery auditor, a follow-up demand letter is expected
- The remittance advice will show the date of denial, which will match the date of the demand letter
Redetermination

- You must send the redetermination request within 120 days from the date of the demand letter
  - You must send it within 30 days of the date of the demand letter to stop recoupment
  - The decision will (should?) arrive within 60 days
- Notification is not generally sent for favorable determinations at level 1
  - Monitor the remittance advices to identify any overpayments, underpayments, and paid or denied cases

The ALJ Level

- Unfortunately, most denied cases elevate to the administrative law judge (ALJ) level
- Start the appeal on the first level (redetermination)
- Prepare your argument just as if you were presenting to an ALJ

Why Write a Letter at Level 1?

- Writing a letter proves to your MAC that you are standing firm on your decision to admit the patient
- Starting your defense at level 1 allows most “arguments” to be addressed by the time of the ALJ hearing
Why Write a Letter?

- Your letter of appeal to the MAC, and your letter to the QIC, will be in the record when and if the ALJ receives it
- If the ALJ is considering a favorable “on-the-record” decision, your letter may help lead to a favorable decision
- If you do not send a letter of appeal, an ALJ may believe that the same argument you will make at this level should have been made at a lower level of appeal

A Good Reason to Write an Appeal Letter: ALJ—Paid on the Record

- An ALJ may decide to overturn the case based entirely upon the findings in the record
- A thorough appeal letter will assist the process and guide the ALJ to the medical necessity of the case
- You will receive a call or a fax from the OMHA regarding this favorable “on-the-record” decision

Letter of Appeal: Where Do I Start? What Does an ALJ Want to Know?

- What happened?
  1. The IRF admitted a great case that was denied.
  2. Who denied it, and why was it denied?
  3. Why do you disagree? Tell the story of the patient, beginning prior to the acute stay if possible.
  4. How does this case fit CMS’s regulations and guidance?
  5. What were the patient’s goals? What about barriers?
Letter of Appeal: Where Do I Start? What Does an ALJ Want to Know?

- What happened?
  6. What happened at the IRF? Link the concerns/comorbid conditions/risks identified during the pre-admission screening to planning and assessments/evaluations/interventions in the IRF.
  7. Explain why this patient would have been in harm’s way in a lesser level of care.
  8. Discuss the intensity of therapy and the planned therapy interventions.

Explain the Risks Involved

- Documenting risks will provide tremendous support during an appeal
- It would be impossible for a physician to prepare an infinite list of risks involved for any of a patient’s specific conditions, medications, or limitations
  - If even one particular risk materializes into an acute complication, it could lead to further risks, which could start a potential downward spiral of multi-system complications

Supporting the Case with Risks

- To a medical professional, some risks are “common knowledge,” and they involve unwritten standards of care
  - But not to an administrative law judge!
- Even if some of these risks are not documented in the record, an ALJ will typically accept testimony from a physician stating that these risks were considered in the admission process, even if not documented, because these risks are “known” (learned) standard-of-care issues
Supporting the Case with Risks

- What is the risk of uncontrolled pain? In the setting of hypertension? In the setting of severe anxiety?
- What is the risk with urinary retention? With underlying hypertension? With added pain?
- What is the risk of infection? With uncontrolled diabetes? With administration of prednisone? What about a high dose of insulin with an increase in activity?
- What is the risk of DVT? In the setting of immobility, advanced age, and post-joint replacement surgery?
- What is the risk for bleeding? Coumadin? Diverticulosis? Falls?

ALJs Are Looking for Follow-through

- If the pre-admission screen states that Ms. Jones has hypertension, that it will require close assessment as she increases her activity, and that her blood pressure will be assessed only once during each shift, the ALJ will be puzzled because blood pressure can be assessed once each shift in a SNF.
- But, if the pre-admission screening states that Ms. Jones has hypertension, that it will require close assessment as she increases her activity, that her blood pressure will be evaluated four times each day and as needed during therapy sessions, then the documentation places the care above that offered at a SNF.

ALJs Are Looking for Follow-through

- ALJs will want to know whether the IRF team followed through with assessments related to conditions identified on the pre-admission screen.

<table>
<thead>
<tr>
<th>Documented on Screen</th>
<th>Followed up at IRF?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal sodium</td>
<td>Repeat lab? Evaluate for Hx?</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Closely follow B/P assessment 3x–4x a day for first few days and during therapy</td>
</tr>
<tr>
<td>Abnormal glucose levels</td>
<td>Finger sticks, labs, and education</td>
</tr>
<tr>
<td>Risk for DVT</td>
<td>All prophylactic measures and assessment</td>
</tr>
<tr>
<td>Depression/anxiety</td>
<td>Consultation, stable environment, motivation, medication adjustment as needed, and assessment</td>
</tr>
</tbody>
</table>
According to CMS, assessments and evaluations due to risks are medically necessary services. "For example, suppose that on admission to the IRF, a patient has a risk for a clinical complication that would complicate the patient’s participation in the rehabilitation therapy program. This is information that would be a reason for the IRF stay to be reasonable and necessary even if the patient’s clinical complication is well managed by the IRF and does not actually cause any difficulties during the patient’s rehabilitation therapy program.” —CMS, November 12, 2009, National Provider Conference Call (transcript and audio file, p.6)

**Would This Patient Be Safe in a SNF?**

- Would this patient be safe in a lesser level of care?
- With only one RN in the building at night, who will perform assessments?
  - What happens if this RN is busy with another patient, and the patient has chest pain?
  - Who will administer IV medications and assess the patient for adverse reactions?
  - What if the patient’s hemoglobin drops below 8 and she becomes symptomatic? Would it be recognized?
  - Immediate transfer to the hospital would be required
  - Is there enough staff for bladder retraining? Are bladder scans available?

**Lesser Level of Care**

- Would this patient be in harm’s way without these assessments and evaluations as the patient’s level of activity increases to three hours a day?
- Compare twenty-four-hour RN coverage in an IRF to eight-hour RN coverage or a high patient-to-RN ratio in a SNF
- Who will provide the required evaluation and assessment if no RN is available?
Don’t Be Misled by the Previous Living Setting or Discharge Status

- According to CMS, whether the patient resided in a SNF or a nursing home or had a plan for discharge to a SNF after the IRF stay is not relevant—what matters is whether the patient met the admission criteria.

Don’t Be Misled by the Previous Living Setting or Discharge Status

“Whether the patient comes to the IRF from an acute care hospital, a critical access hospital, a skilled nursing facility, or any other facility, the patient will be considered an ‘approved’ IRF admission as long as he or she meets all of the coverage requirements.”

- Admission from a SNF is not a “typical” admission—approximately 1% of all admissions are admitted from a SNF.
- Discharge to a SNF is not a “typical” discharge—approximately 13% of discharges are to a SNF or a subacute setting.

Don’t Be Misled by the “Lesser Level of Care” Argument

- MAC and RAC reviewers are continuing to use “could have been treated in a lesser level of care” as a reason for denial, despite CMS’s guidance.
- Whether or not the patient could be treated in a lesser level of care cannot be considered as a deciding factor—what matters is whether the patient met the criteria for admission to an IRF.
On page 7 of the transcript and audio file for the IRF PPS Coverage Requirements National Provider Conference Call on November 12, 2009, CMS stated, “Notice that nowhere on the slide and nowhere in this presentation are we going to talk about whether the patient could have been treated in a skilled nursing facility or another setting of care. Under the new requirements, a patient meeting all of their required criteria for admission to an IRF should be appropriate for IRF care whether or not he or she could have been treated in a skilled nursing facility.”

Defend your case!

Many reviewers are trained to evaluate medical necessity by using InterQual criteria

Unfortunately, reviewers are using this to deny current IRF cases

Does InterQual weigh the risks of the patient, particularly as the patient increases the level of activity?

Neither the current IRF regulations nor guidance from CMS recommends using InterQual criteria as a basis for admission to an IRF

Remind your MAC that this is not a CMS requirement or recommendation

Many denials that include “technical” issues have been overturned

Be aware that “technical” issues can be appealed, although they are sometimes a bit difficult

An example is a pre-admission screening that was not signed within the required time frame due to a simple human error—CMS states that this regulation is intended to ensure that the physician is fully aware of all issues and changes with this patient prior to admission

Can you prove that the physician was fully aware of the issues and changes and simply failed to sign the form in the required time frame?
What about “Technical Denials”?

- Look for other evidence that the physician was aware of the issues
- Did the rehabilitation physician document a progress note in the acute hospital record within the forty-eight hours before the patient’s admission to the IRF?
- Did the rehabilitation physician participate in “hospital rounds” each morning? Does the record include documentation of a telephone conversation with the attending physician regarding the patient? Did the case manager in the acute setting document information regarding an IRF transfer?

- Is the physician willing to sign an affidavit, or a simple letter, attesting that he was fully aware of the issues and simply failed to sign the pre-admission form?
- Ask forgiveness from your MAC, and assure them that processes and policies are in place to ensure compliance

What about “Technical Denials”?

- For example, did you forget the prognosis in the IOPOC?
- What was the discharge plan for the patient? Was the plan to return home without assistance?
- Although this situation does not completely meet CMS’s guidelines, denying the entire case for this one reason seems unrealistic, particularly if the prognosis has been alluded to in another area of the record
- We are all human!

Forget a Required Component?

- There may be other areas of the record that can be used for reference
- For example, if you forget the prognosis in the IOPOC?
- What was the discharge plan for the patient? Was the plan to return home without assistance?
- Although this situation does not completely meet CMS’s guidelines, denying the entire case for this one reason seems unrealistic, particularly if the prognosis has been alluded to in another area of the record
- We are all human!
Organization for RAC/MAC Audits

- Ensure that your RAC/MAC knows the precise address and contact person to use when sending medical record request letters
- Who will be in charge of the RAC reviews at your facility?
- Who will be in charge of copying records and/or scanning them to a CD?
- Who will be in charge of tracking your RAC medical record requests?
- Where will you store copies of records?
- What has your facility decided regarding recoupment?

Organization Is Key to Audits

- This must be a team effort
  - Employees typically come and go
  - The team must be able to plug the gaps if a key team member leaves
  - Determine corrective actions that your facility must take to avoid future improper payments

Need Assistance with Appeals?

- UDSmrt offers appeals management services
  - Our team of appeals experts will review records, create detailed and relevant appeals, and follow your claim to resolution
  - When the appeal is complete, we provide feedback for your team regarding any issues of concern with your records
  - For information regarding our appeals management services, contact Kathy Dann at 716-817-7826 or kdann@udsmr.org