HEALTH CARE HERALD

News From ProMed Health Care Administrators & Pomona Valley Medical Group, Inc.
Spring 2007

President's Message

By Jeereddi A. Prasad, M.D., President

Spring has arrived. Some parts of the world celebrate New Year at this time. Best wishes to all the people celebrating spring as well as the New Year.

Growth in the managed care enrollment appears to be stagnant. We have re-elected the Board of Directors at the Annual Shareholder's meeting.

The IPA is financially stable. In the year 2007 in addition to enhancing provider compensation and Shareholder's value the IPA would be looking for strong strategic alliances to strengthen our position.

Again, wishing all of you a good spring and summer to come. Thank you.

Chief Executive Officer's Bulletin

By Kit Thapar, M.D., CEO/CMO

I am happy to report that we just concluded a new contract with PacifiCare for one additional year and with Aetna for two years. We are in the middle of our negotiations with Health Net for an extension of the contract with new terms and conditions.

HMO membership continues to languish due to introduction of new insurances being offered to employers and members. This is a National trend and not unique to ProMed. We will be revisiting our contract with CHP Medi-Cal HMO in June this year.

Nothing much to report otherwise. Enjoy the coming months as we get some wonderful weather.

INSIDE THIS ISSUE

HOW TO DEAL WITHINSULTS

ONCE THERE WAS A DISCIPLE of a Greek philosopher who was commanded by his master for three years to give money to everyone who insulted him. When this period of trial was over, the master said to him: "Now you can go to Athens and learn wisdom.'

When the disciple was entering Athens he met a certain wise man who sat at the gate insulting everybody who came and went. He also insulted the disciple, who immediately burst out laughing. "Why do you laugh when I insult you?" said the wise man.

"Because," said the disciple, "for three years I have been paying for this kind of thing and now you give it to me for nothing." "Enter the city," said the wise man, "it is all yours."

JACK KORNFIELD and CHRISTINA FELDMAN
Soul Food
HarperSanFrancisco

PROVIDER SERVICES

By: Dawn Tumser, Provider Relations Supervisor

CHANGES TO THE HCFA 1500 CLAIM FORM

As you may already be aware, the paper claim forms are changing in 2007. The HCFA 1500 Form will be changing to CMS 1500 Form. The CMS 1500 Form offers a field that the HCFA 1500 did not offer. A field to bill with your National Provider Identifier (NPI). The target date for implementation of the CMS 1500 Form is June 1, 2007.
Also, the UB-92 will be changing to UB-04. These changes will comply with the new NPI submission requirements.

You can also expect to see the following differences in the new CMS 1500 Form:

- **Box 17-17b:** This box can be used to enter the referring physician's provider name, provider identification number (PIN) and NPI.
Box 24D: This box was altered to allow up to four modifiers.
- **Box 24J:** This box can be used to enter the PIN and NPI of the performing physician.
- **Box 32-32b:** This field can be used to enter the name and address of the location where services were rendered. Also, enter the NPI and PIN of the location where services were rendered in Box 32a and Box 32b.
- **Box 33-33b:** Use this box to enter the name, address, telephone number and PIN number that is assigned to the practice location for which the claim was submitted. Enter the provider's NPI in box 33a and the PIN number in box 33b.

For more information regarding form changes, you can visit the following Websites:

- CMS-1500: www.nucc.org
- UB-04: www.nubc.org

HEALTH EDUCATION

ProMed's contracted HMO's make available to your members a wide variety of health education materials in mandated state health topics that have been reviewed for cultural sensitivity, appropriate reading level, and medical accuracy.

Materials are available in the following languages: English, Spanish, Armenian, Chinese, Farsi, Khmer, Vietnamese, Russian, and Korean.

Topics include:

- Birth Control Options
- Controlling High Blood Pressure
- Controlling your Cholesterol
- How to Breastfeed
- How to Prevent the Spread of Tuberculosis
- Nutrition During Pregnancy
- What are STDs?
- What is Asthma?
- What is Prenatal Care?
- What is Type 2 Diabetes?

If you would like to order copies of these Health Education Topics, please contact Dawn Tumser at (909) 932-1045 Ext. 1005.

PROVIDER UPDATES

New Providers
Rajivinder Brar, DO-Family Practice
Ericka Hong, MD-Pediatrics

Provider Address Changes
Debra Turull, MD
1902 Royalty Drive, #240
Pomona, CA 91767
(909) 629-7999

Linda Hillebrand, DO
10837 Laurel Street #206
Rancho Cucamonga, CA 91730
(909) 989-2700

Jaime Gonzalez, MD
716 E. Mission Blvd., #D
Pomona, CA 91766
(909) 865-2332

Providers No Longer with PVMG
Subhash Varshney, MD
Sandra Zaragoza-Kaneki, MD
Clyde Harris, MD
Joseph Tran, DO

ProMed News in Review – Qtr. 1, 2007 Memos

By Karen Harvey, Executive Assistant

DUPLICATE AUTHORIZATIONS – January 12, 2007

ProMed is currently receiving excessive DUPLICATE authorizations. This takes time out of our busy schedule to input these duplicate authorizations, as required by the Health Plans.

Please DO NOT send DUPLICATE authorizations. If you have not received your authorization within 5 working days, please feel free to call Laura Olasaba at (909) 932-1045, ext. 1091.

PROVIDER STATE MEDICAL LICENSE January 17, 2007

We have recently encountered an issue with a physician who did not renew his Medical Board license prior to the expiration date. This presents a huge risk management issue for the IPAs. As such, we have implemented a new policy.

The policy states that any contracted provider who does not renew his/ her State medical license will be terminated from the IPA within 1 working day after the license date expiration.

Copies of the actual policy and procedure are available upon request.

ORTHOPEDIC PANEL UPDATE – January 18, 2007

Please be advised of the following changes to the PVI local Orthopedic Specialist panel:

- ✓ *Dr Clyde Harris is **no longer** a contracted specialist with Pomona Valley Medical Group, effective 12/22/06.*
- ✓ *Dr Neeraj Gupta is not available for direct referrals as he is completing a fellowship training. He is only available part time.*

- ✓ *will see some PVMG pediatric orthopedic problems. Prior authorization is required..*
- ✓ *Dr Robert Koelsnik will see some Orthopedic hand cases. Prior authorization is required>*

The current PVMG contracted local Orthopedic panel specialists are:
Dr Albert Chong
Dr Raja Dhalla
Dr Satish Lal (He also will perform spinal surgery)
Dr Gregory Lercel
Dr Mazin Sabri
Dr Mahipal Shah
Dr Jay Shah
Dr Karim Shaikley

NEW LLUHC CONTRACT FOR PEDIATRIC MEMBERS – March 12, 2007

Effective this date, ProMed now has a contract in place for all commercial Pomona Valley Medical Group and Upland Medical Group Pediatric members (age 0 thru 18 years) with Loma Linda University Health Care. The purpose of this contract is for higher level of care Pediatric referrals to a tertiary center.

Prior authorization **IS** required for:

- Initial consults with specialist(s)
- Follow up visits with specialists
- OP diagnostic testing
- Any other visits at Loma Linda and/or wi Loma Linda physician.

As usual, we appreciate your cooperation in this matter.

Documentation and Coding – March 19, 2007

PacifiCare has contracted with a physician who is also a certified coder to provide a monthly newsletter on Documentation and Coding.

The purpose of this newsletter is to provide information that can be utilized to increase

ProMed News in Review *continued on page 4*

documentation and coding practices, which will facilitate a more accurate patient health status. Each month a new subject will be addressed.

Please recall, CMS (Center for Medicare and Medicaid Services) reimbursement to IPAs is based on the morbidity of Medicare enrollees. Therefore, failure to code patient medical conditions appropriately will decrease payments to IPA physicians from CMS.

It is ProMed's intention to share these newsletters monthly with our contracted IPA PCPS. Additionally, each month's topic will also be shared with our appropriate contracted specialists.

January 2007 Topic: Rheumatology
March 2007 Topic: Cancer Related Diagnoses & Diabetic Nephropathy

If you have any questions or suggestions on specific coding or documentation issues you may:

Contact Angelice Wilson at angelice.Wilson@phs.com **OR** Contact Dr Kit Thapar or Barbara Guerra at ProMed.

We trust you will find this information useful to your practice.

ProMed Offices Closed

By Mary Dodds, Executive Assistant

ProMed Health Care Administrator offices including the corporate offices of Pomona Valley Medical Group and Upland Medical Group, will be closed on the following dates:

Monday, May 28, 2007 Memorial Day
Wednesday, July 4, 2007 Fourth of July

As always, an on-call case manager (nurse) is available. The on-call nurse can be reached by calling the regular office number (909-932-1045) and following the prompts to speak with the on-call nurse. If you have any questions about ProMed's Holiday schedule, please call Mary Dodds at 909-932-1045 x2001.

After Hours Access Information

By: Barbara J. Guerra, RN, Director UM/QM

1. PCP Physicians must provide access to appropriate triage personnel and emergency
services 24-hous a day, seven days a week.

2. Medical triage during business Hours

All PCP sites must have licensed staff available for telephone or on site triage for Members during normal business hours. It is expected that all licensed triage personnel use appropriate medical judgment in determining the disposition of the patient.

- Members must be advised, as part of their instructions, that they should call 911 and seek emergency care if they think they are dealing with a serious acute medical emergency or go to the nearest ER or urgent care.

3. After Hours PCP Access

- ***All PCPs must have arrangements in place for telephone access 24 hours per day, 365 days per year.***

- ***The number listed for the PCP in the members ID card should be the 24-hour access number for that PCP and/ or IPA triage system.***

Members must be able to reach their PCP, a covering physician or a licensed triage person

- ***Approved licensed triage personnel include registered nurses, nurse practitioners or physician assistants.***

Answering services

- ***Answering service personnel cannot perform triage unless they are in one of the previously mentioned categories.***

- ***Members must be able to access their PCP or the covering personnel within 30 minutes of their initial call.***

- Members must be advised, as part of their

instructions, that they should call 911 and seek emergency care if they think they are dealing with a serious acute medical emergency or go to the nearest ER or urgent care.

Claims Dept. Update

By Michelea Stanford, Claims Manager

I would like to introduce myself Michelea Stanford, Claims Manager and my Claims Management staff. Linda Haston- Claims Supervisor and Leticia Anguiano- Compliance Supervisor. My staff and I are open and here to Help and Resolve any claim issues you may have.

Global Services:
Our claims department uses an Unbundling System called Virtual Examiner that follows Medicare guidelines when processing claims. When ever you have issues on how a claim has been processed per Medicare unbundling rules, a good websight to use regarding Unbundling Rules is:
ttp://www.medicarenhic.com
The rules are found in the Local Coverage Determination (LCD) for each kind of service.

New CMS 1500 Form:
The new CMS 1500 form is being revised to include the NPI number. The Effective date 4-1-07 of the new CMS 1500 form has been extended to 6-1-07.

For more information on the form, Go to:
http://www.nucc.org/content/view/12/35/

PROFESSOR OSWALD AVERY worked for many years in a small laboratory at the hospital of the Rockefeller Institute in New York City. Many of his experimental predictions turned out wrong, but that never discouraged him. He capitalized on error. His colleagues remember him saying, "Whenever you fall, pick something up."

CLIFTON FADIMAN
The Little, Brown Book of Anecdotes
Little, Brown and Company

BIRTHPLACE OF
A BRIGHTER FUTURE

AS I CONCENTRATE ON EACH WORD of this thought, "now" slips by me into the past. My past, then, is nothing more than a history of how well I dealt with each irretrievable "now."

The future is nothing more than an approaching series of 'nows." During one of these 'nows," I must make a decision that all future "nows" will be different. A brighter future grows out of a brighter "now." Therefore, my future improves only as I make better use of the current moment.

It's the time remaining that counts, but just as important is my understanding of that profound truth. My willingness to accept responsibility for improving that time will determine the quality of the rest of my life.

The speed at which "now" becomes the past is staggering. Yet, if I commit my God-given strengths to improving each of these approaching "nows," the faith in my bright new future will be exhilarating! For I realize that the same velocity that carries this "now" into the past can carry me at the same rate toward exciting moments of the future when ever-increasing goals become reality.

A year yet to be is unborn, untarnished, and full of promise. One of those brand-new years – bright with potential, accomplishment, and joy – will be delivered to me tomorrow at dawn. My choice is to accept it as it is given, or through habit, mold it into the shape of years past.

The challenge is clear. The choice is mine. Challenge accepted!

DANNY COX
There Are No Limits
Career Press

MDQuickFax™ Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

Common Rheumatologic Diagnoses: Documentation and Coding

Example: Progress note: systemic sclerosis involving the lungs Diagnosis codes: 710.1, 517.2

There are several common Rheumatologic or Connective Tissue diseases that are important to diagnose, document in a progress note, and then code in a claim or encounter at least once each calendar year. When a disease such as rheumatoid arthritis results in complications that impact other organ systems, you should document the causal relationship in your note and submit diagnosis codes for the underlying disease plus codes for the affected organ system.

ICD-9 code	Documentation
710.0	systemic lupus erythematosus (SLE)
710.1	systemic sclerosis (also add 359.6 if complicated by systemic inflammatory myopathy) (also add 517.2 if lung involvement in systemic sclerosis)
710.2	sicca syndrome (including Sjőgren's syndrome)
710.3	dermatomyositis
710.4	polymyositis
714.0	Rheumatoid Arthritis (RA) (also add 357.1 if complicated by polyneuropathy) (also add 359.6 if complicated by systemic inflammatory myopathy)
720.0	ankylosing spondilitis
720.2	sacroiliitis, not elsewhere classified
725	polymyalgia rheumatica

Examples: The correct documentation and coding for a patient with a connective tissue disease seen at least once each year might be:

- **Progress note:** polymyalgia rheumatica responding well to treatment
- **Diagnosis code:** 725

- **Progress note:** polyneuropathy due to long-standing rheumatoid arthritis
- **Diagnosis codes:** 714.0, 357.1

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record, which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

MDQuickFax™ Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

Making the Diagnosis: Cancer vs. "History of cancer"

1) A common error that physicians make in documentation and coding is that they are not clear about the correct way to handle the diagnosis of cancer.

If a patient has an **active primary cancer, active metastases, or is on active treatment**, then the correct documentation and coding is cancer. For example:
• **Progress note:** 84 yr woman s/p mastectomy for breast cancer, on tamoxifen
• **Diagnosis code:** 174.9 (breast cancer)

However, if a patient no longer has active disease or metastases and is no longer on active treatment, then the correct documentation and coding is "history of cancer." For example:
• **Progress note:** history of Dukes A colon cancer, no recurrence, no current treatment
• **Diagnosis codes:** V10.05 (personal history of colon cancer)

Here are the most common solid tumor cancers:

ICD-9 Documentation "History of…" and ICD-9 code

153.9 malignant neoplasm of colon (history of colon cancer = V10.05)
162.9 malignant neoplasm of lung (history of lung cancer = V10.11)
174.9 malignant neoplasm of female breast (history of breast cancer = V10.3)
185 malignant neoplasm of prostate (history of prostate cancer = V10.46)
188.9 malignant neoplasm of bladder (history of bladder cancer = V10.51)

Increased surveillance or testing for cancer by itself does not lead to the diagnosis of active cancer. If the patient above with a history of colon cancer is getting annual screening colonoscopy, but has no evidence of active cancer, the documentation and coding is still "history of colon cancer".

A second common error is to omit documentation and coding for metastatic cancer. Here are the most common sites for metastases that should be documented and coded if present:
196.9 metastatic cancer to lymph node (note: there are no "history of" codes for
197.7 metastatic cancer to liver metastatic cancer)
198.3 metastatic cancer to brain
198.5 metastatic cancer to bone

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record, which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

June 6, 2007

MDQuickFax™

Helping doctors get useful information, quickly.

Zack Gerbarg, MD, CPC (certified professional coder), editor

Making the Diagnosis: Diabetic Nephropathy

One of the most common errors physicians make in documentation and coding is that they forget to actually make a clear diagnosis. A common example is diabetic nephropathy.

Almost all physicians check for microalbuminuria in patients with long-standing diabetes. But when the microalbuminuria level is persistently abnormal, they often forget to document the diagnosis of diabetic nephropathy and instead simply write "diabetes with microalbuminuria". The resulting diagnosis is coded as uncomplicated diabetes and an abnormal lab test:

Doctor documents: "diabetes with microalbuminuria"
Correct ICD-9 codes: 250.00 – uncomplicated diabetes
791.0 – proteinuria

Doctor documents: "diabetic nephropathy"
Correct ICD-9 codes: 250.40 – diabetic nephropathy
583.81 – nephritis or nephropathy in diseases classified elsewhere

In addition, **every patient who has or is suspected of having chronic kidney disease (CKD) should have the stage of CKD determined and documented.** This can be easily done by estimating the glomerular filtration rate (GFR) based on the patient's serum Creatinine, age, gender, height, weight, and race. Some laboratories automatically do the calculation whenever you order a serum Creatinine while most others will do it if requested.

What is the correct way to diagnose, document, and then code diabetic nephropathy?

1) Start with a patient who has diabetes
2) Order lab tests for microalbuminuria, serum Creatinine, and estimated GFR
3) Based on the results; determine if the patient has chronic kidney disease and the stage of the CKD: e.g. GFR = 30-59 mL/min/1.73m^2 is consistent with Stage 3 CKD
4) Rule out causes of renal disease other than diabetes: e.g. medication-induced
5) Document accurately and completely and submit the correct codes with your claim

Examples: The correct documentation and coding for a patient with diabetic nephropathy seen at least once each year might be:

- **Progress note:** diabetes complicated by stage 3 CKD
- **Diagnosis codes:** 250.40, 585.3

- **Progress note:** end stage renal disease due to uncontrolled diabetes
- **Diagnosis codes:** 250.42, 585.6

Basic principles of diagnosis coding:
Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record, which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

- **Diagnosis codes:** 250.52, 362.01

Basic principles of diagnosis coding:

Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record, which is dated and signed by a physician. **A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.**

The information provided here is for general advice for appropriate documentation and coding. Final decisions should be based on review of standard reference materials.

2006 PVMG Member Satisfaction Survey Results

Based on survey tool PVMG utilizes. 7 Major areas

Methodology: 30 questionnaires mailed to each PCP; Total surveys distributed: 3300
Responses received- 2533. Response rate - 76.5%

2006 Individual Year Results

Class	# MD	Access	Rec/Ex Rm	Wait time	Cust Rel	Bus Office	Staff care	MD care	TTl Sat
FP	30	**94.8%**	96.7%	**95.5%**	98.6%	99.6%	98.9%	98.9%	98.0%
IM	23	95.7%	98.5%	96.2%	99.5%	98.5%	99.2%	99.5%	98.2%
PEDS	15	95.8%	94.8%	93.6%	98.4%	98.5%	98.6%	99.6%	97.1%
TTL PCP	**68**	**95.8%**	**94.8%**	**93.6%**	**98.4%**	**98.5%**	**98.6%**	**99.6%**	**97.1%**

5 PCPs (7%) of the 87 surveyed achieved scores in at least 1 caetgory indicated above below benchmark of 85%.

Cumulative results- Years 2004 thru 2006 Results (3 years)

Class	# MD	Access	Rec/Ex Rm	Wait time	Cust Rel	Bus Office	Staff care	MD care	TTl Sat
FP	103	**92.1%**	**94.1%**	**93.7%**	97.8%	99.4%	97.8%	98.2%	96.3%
IM	52	92.3%	96.1%	95%	99.6%	99.1%	98.6%	99%	97.1%
PEDS	33	**95.7%**	**94.4%**	**94.1%**	98.8%	98.6%	98.4%	98.7%	96.7%
TTL PCPS	**188**	**93.3%**	**94.9%**	**94.3%**	**98.7%**	**99%**	**98.3%**	**98.7%**	**96.7%**

June 6, 2007

FINAL REMINDER
THE NPI DEADLINE IS JUST AROUND THE CORNER

DON'T DELAY ONLY 46 MORE DAYS!
APPLY BEFORE MAY 23, 2007

By Jacqueline Caya, Contracts Manager

The Health Insurance Portability and Accountability Act (HIPAA) mandates that a standard, unique identifier replace any identifiers currently in use for health care providers. As you may already be aware, the identifier officially adopted to comply with this requirement is the National Provider Identifier (NPI). This unique identifier is intended to simplify the administration of certain health care information and improve efficiency and effectiveness of standard transactions.

NPI's are assigned as 10-digit, intelligence-free numbers. Intelligence-free means that the numbers do not carry information about the health care provider, such as the state in which he or she practices or his or her provider type or specialization. This number will eventually replace all other identification (ID) numbers used in electronic transactions, including health plan provider ID, but does not replace the provider's Tax ID Number (TIN), which will still be required on claims submission transactions. Additionally, this number remains with the provider permanently regardless of job or location changes.

All providers who complete electronic transactions **MUST** obtain an NPI to identify themselves in HIPAA-standard transactions.

These providers include:

- Physicians and other practitioners, including, but not limited to, dentists, physician assistants, chiropractors, nurses, licensed social workers, physical therapists, ophthalmologists, and clinical psychologists.
- Medical Groups/IPA's
- Hospitals, nursing homes and other institutional providers.
- Pharmacies, including online pharmacies, and pharmacists.
- Suppliers of durable medical equipment (DME)

STEP-BY-STEP PREPARATION

ProMed Health Care Administrators encourages you to begin preparing for the NPI rule if you haven't already. The steps below can help you with obtaining and notifying ProMed of your NPI before the deadline occurs.

STEP 1 - How to Apply for an NPI:

The Centers for Medicare and Medicaid Services (CMS) have contracted with Fox Systems, Inc. to serve as the NPI Enumerator to assign NPI's to providers. The National Plan and Provider Enumeration System (NPPES) issue the NPI. You may apply for an NPI by doing one of the following:

1. Complete the web-based application at: https://nppes.cms.hhs.gov
2. Fill out a paper application and send it to:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

A copy of the NPI application is available online at: http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIapplication.pdf or by calling Fox Systems at (800) 465-3203 or TTY (800) 692-2326. You may also email customerservice@npienumerator.com for additional information or questions regarding applying for an NPI.

Be sure to include complete and accurate information on your application and save a copy of your confirmation form. The Health Plans may request a copy of your conformation form at a later date for validation purposes.

STEP 2 - Notify ProMed of Your NPI:

After you have applied for and been assigned an NPI, please fax your NPI to Dawn Tumser, ProMed Provider Relations Supervisor at FAX (909) 932-1065.

You may receive notices about the NPI from many of the Health Plans with which you do business. Remember that you need to apply only once for an NPI. The same NPI is used for every Health Plan. The transition from existing health care provider identifiers to NPI's in standard transactions will occur over the next couple of years. **We urge health care providers to apply for an NPI now. While the NPI must be used on standard transactions with large Health Plans no later than May 23, 2007,** health care providers should not begin using the NPI in standard transactions on or before the compliance date until Health Plans have issued specific instructions on accepting the NPI. Health Plans will notify you when you can begin using NPI's in standard transactions. You should be aware that Health Plans might request that you begin using our NPI prior to the compliance date. Applying for an NPI does not replace any enrollment or credentialing processes with any Health Plan, including Medicare.

Special Dates

APRIL FOOLS' DAY

SUNDAY, APRIL 1, 2007

PASSOVER BEGINS

TUESDAY, APRIL 3, 2007

EASTER

SUNDAY, APRIL 8, 2007

TAX DAY

TUESDAY, APRIL 17, 2007

ADMINISTRATIVE PROFESSIONALS DAY

WEDNESDAY, APRIL 25, 2007

CINCO DE MAYO

SATURDAY, MAY 5, 2007

NURSES DAY

SUNDAY, MAY 6, 2007

MOTHER'S DAY

SUNDAY, MAY 13, 2007

MEMORIAL DAY

MONDAY, MAY 28, 2007

FLAG DAY

THURSDAY, JUNE 14, 2007

FATHER'S DAY

SUNDAY, JUNE 17, 2007

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