CURRENT TOPICS IN GERIATRIC MANAGEMENT FROM A CMS STANDPOINT

Jeffery A. Kerr D.O. CMD
113TH MAOPS Convention
April 16, 2011
Goals

- To discuss new changes in documentation needed (for CMS reimbursement) for home health, hospice, laboratory services, durable medical equipment
- To discuss new quality measures on the forefront that determine your quality of care
- To discuss new changes in prescribing scheduled drugs in a long term care setting
- To discuss the Prior Authorization process with Medicare Part D and MoHealthNet (Missouri Medicaid)
WHY?

- The burden of multiple calls from agencies, pharmacies, DME providers interrupts your day, productivity, and ultimately, the time you spend caring for your residents.
- The provider’s (physician, PA, NP) signature on any document that authorizes eligibility for CMS reimbursement becomes a threat for medicare/medicaid fraud if you don’t know what you are signing and the rules of engagement.
Why all the added paperwork?

- CMS feels medicare/medicaid fraud is common and these rules decrease the risk for overzealous utilization and fraud/abuse.
- I personally feel the more hurdles we have to jump, the less we jump hurdles (and our residents ultimately pay the price)
ALWAYS

- Be an advocate for your residents
- Develop processes to deal with the paperwork burden
- Direct the third party vendor’s request for services, don’t let them direct you
- Keep abreast of new changes in Medicare and Medicaid by getting email alerts, belonging to professional organizations (AMDA, NGNA, AGS to name a few), and questioning new requests for information from vendors
Be Aware

- Nursing facilities may contract with organizations to provide services in the long term care facility (including AL and Residential Care). Your signature on the dotted line is what makes all the wheels start turning. Don’t sign anything you don’t feel comfortable with!
Generally

- Other insurance products follow suit with CMS on requirements
Home Health Services

- In doing discharge planning, I would recommend not certifying home health for more than 30 days, unless you are following the resident in your office or doing home visits. The 30 days allows them to re-establish with their PCP. Your are ultimately responsible for the patient during the certification period.
Home Health Services

- Must have a defined need for services
  - Management of wound care
  - Teaching of the disease process
  - Medication management and teaching
  - PT/OT/ST
  - Observation and assessment
Home Health Services

- Unacceptable reasons to provide home health services
  - Medication set-up
  - Lab draws

Medication set-up and lab draws CAN NOT be the sole reason for home health services. Skilled nursing can perform these duties as long as there is another medical condition that is the primary reason home health services is providing care.
Home Health Services

Clinical findings supporting Home Health Services:

1) Any lab findings
2) Radiology reports
3) Any physical/mental findings upon assessment that relates to the medical conditions that require home health services
Home Health Services

Clinical Findings Supporting Homebound Status:

1) Oxygen dependency
2) Weakness
3) Debility
4) Decrease in functional ability
5) Cognitive deficits
Home Health Services

- Resident must be homebound
  - Allowed to go out of home for physician appointments and church
Home Health Services

- Effective January 1, 2011, a physician who certifies a patient as eligible for Medicare home health services MUST see the patient.
- The law allows the requirement to be met if a non-physician provider (NPP) sees the patient, when the NPP is working for, or in collaboration with, the physician.
Home Health Services

- Physician must document on home health certification form that the physician or NPP saw the patient and document how the patient’s clinical condition supports a homebound status and need for skilled services.

- Face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.
Home Health Services

- Medicare allows a hospital-based physician to initiate the home health order and complete the face-to-face examination (and establish and sign the plan of care), then handing off to the community-based physician to review and sign off on the plan of care.

- In rural areas, Medicare allows the face-to-face encounter to occur via telehealth, in an approved originating site.
Home Health Services

- Additional information and clarification can be obtained at:
  - www.cms.gov/center/hha.asp
Hospice Services

- Must be directed at the nursing home level by the physician
- The Hospice medical director is the default physician but usually has limited knowledge in long term care issues (unless a geriatrician or physician working in LTC facilities)
- CMS has mandated more involvement of the Hospice medical director to oversee your work
Hospice Services

- Remember to use the GV and GW modifiers in order to be paid by CMS for hospice visits
- MoHealthNet (Missouri Medicaid) considers all physicians/PA/NP payments included in the payment made to Hospice. I would recommend a contract with the hospice to pay you for your services at the medicare allowable rate.
Hospice Services

- Tricare also considers payment made to hospice the global fee (even if you are not the hospice medical director) Variable interpretations. Watch your EOB’s!
- CMS will not reimburse you if you are seeing a hospice patient who is enrolled in a hospice for which you serve as the medical director
Hospice Services

- I recommend making a call to the hospice when you feel a resident is no longer meeting criteria. The physician has signed the certification form stating the need initially. I can see this becoming a medicare abuse/fraud issue if the resident is left on and you have recognized criteria are not being met and not taken them off service.
Hospice Services

- Recertification periods are every 90 days. If a resident improves during that time (gains weight, no infections, wounds heal) they will be taken off at the recertification time.

- If a resident is on hospice for 6 months, the hospice medical director must make a face to face visit with your resident to determine if the resident still meets criteria.
Hospice Services

- If a resident is on hospice for 180 days, the hospice medical director or hospice NP must make a face to face visit with your resident to determine if the resident still meets criteria.
- If criteria met, the hospice medical director or hospice NP must have a face to face visit each recertification period thereafter (and attest that the visit took place).
Hospice Services

- WHO CAN’T MAKE THE VISIT TO RECERTIFY INTO THE THIRD BENEFIT PERIOD OR LATER???
  - The attending physician
  - Any nurse practitioner not employed by the hospice
Hospice Recertification Periods

- The first 2 are 90 day periods
- After 180 days, the certification periods are 60 days
THE HOSPICE NARRATIVE

- As the attending physician, you are now required to make a narrative statement as to the clinical findings on your resident that lead you to believe their life expectancy is less than 6 months. This is completed when the hospice consult is done.
- Variable requests by hospices for this documentation. Repercussions???
Home Hospital Beds

Documentation:

- Patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed.
- Patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.
Home Hospital Beds

Documentation:

- Patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. (Pillows or wedges must have been considered and ruled out)
- The patient requires traction equipment, which can only be attached to a hospital bed.
HOSPITAL BEDS

- JUST A DIAGNOSIS DOESN’T COVER THE BED
  - S/P JOINT REPLACEMENT
  - RECENT DISCHARGE FROM HOSPITAL
  - RECENT DISCHARGE FROM REHAB HOSPITAL
SPECIAL BEDS

- All have specific requirements to be met.
  - Fixed height hospital bed
  - Variable height hospital bed
  - Semi-electric hospital bed
  - Heavy duty extra wide hospital bed
  - Extra heavy duty hospital bed
FROM A DME PROVIDER........

- “The documentation listed must be in the patient’s chart and not just on a prescription. The physician face to face documentation showing reduced ADL’s without the equipment and resolution of the deficit with safe use of ordered equipment in patient’s chart is what Medicare asks for.”
FROM A DME PROVIDER……..

- “The part of the explanation being in the chart is the hardest thing for us to document as a DME provider, yet it is what Medicare asks for (along with the written prescription)”
- “Medicare guidelines seem beyond complicated at this time”
Manual Wheelchairs

DOCUMENTATION

• Patient has mobility limitations that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home;

AND
Manual Wheelchairs

**DOCUMENTATION**

*Mobility limitation cannot be sufficiently and safely resolved by use of an appropriately fitted cane or walker AND

*Patient is able to safely use a manual wheelchair AND

*Patient’s functional mobility deficit can be sufficiently resolved by the use of a manual wheelchair
Manual Wheelchairs

- The patient home must accommodate a wheelchair (doorways, hallways)
- The patient must use it on a regular basis IN THE HOME.
- The patient has not expressed an unwillingness to use a manual wheelchair in the home
Manual Wheelchairs

- The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.  OR
Manual Wheelchairs

- If the patient is unable to self-propel, the patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.
CLEAR DOCUMENTATION SUGGESTIONS FOR MANUAL WHEELCHAIRS

- What is the patient’s ability to ambulate? If they are able to ambulate, with what type of assistive device is required? If they cannot ambulate, why not?
- How far is the patient able to ambulate?
- How long will ambulation be a problem? Is this a short term non-weight bearing issue?
- Is the assistive device currently being used by the patient safe? If not, why not?
CLEAR DOCUMENTATION SUGGESTIONS FOR MANUAL WHEELCHAIRS

- Is the patient able to transfer in and out of bed and/or in and out of the chair?
- Is there any equipment required for transfers from bed to chair and/or chair to toilet?
- Is the patient able to perform pressure relief/weight shift? If the patient is unable to perform a functional weight shift, documentation should clearly indicate why.
CLEAR DOCUMENTATION SUGGESTIONS FOR MANUAL WHEELCHAIRS

- What is the patient’s sitting and standing balance?
- Is there an objective functional assessment that includes impairment of strength, range of motion, sensation, or coordination of arms and legs?
- Is there presence of abnormal tone or deformities of arms, legs, or trunk, including any spasticity present?
CLEAR DOCUMENTATION SUGGESTIONS FOR MANUAL WHEELCHAIRS

- What are the patient’s neck, trunk, and pelvic posture and flexibility?
- Are there interventions that have been tried in the past by the patient and the results?
- Is there any history of past use of a walker, manual wheelchair, POV, or power wheelchair and the results?
- If the patient has frequent falls, indicate why they are having falls and if the falls are occurring with or without use of an assistive device such as a walker.
TIPS!!!

- If the patient is able to safely ambulate with a cane or a walker a distance that would allow access to all necessary rooms in their home and allow them to perform their Activities of Daily Living, a manual wheelchair would NOT be medically necessary.
TIPS!!!

- If the manual wheelchair is only for use outside the home, it will be DENIED.
- Medical necessity is determined by the patient’s CURRENT condition and not by probable deterioration in the future.
- The medical necessity for a wheelchair is not solely based on diagnosis or medical conditions. There are varying degrees of medical conditions and these medical conditions may be contributing factors to the mobility limitation.
Power Wheelchairs and Power Operated Vehicles

- **STATUTORY REQUIREMENTS THAT MUST BE MET**
  - In-person visit with physician specifically addressing the resident’s mobility needs
  - History and physical examination by the physician or other medical professional (PT/OT) focusing on an assessment of the resident’s mobility limitation and needs IN THE HOME.
  - A prescription must be written after the face-to-face visit has occurred and the medical evaluation is completed
Power Wheelchairs and Power Operated Vehicles

STATUTORY REQUIREMENTS THAT MUST BE MET

- The prescription has the seven required elements
- The prescription and medical records documenting the face-to-face visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.
Power Wheelchairs and Power Operated Vehicles

- Requires a face to face visit with resident specifically addressing the patient’s mobility needs
- Must be a history and physical examination by the physician
  - You may elect to refer the resident to another medical professional (PT or OT) to perform part of the evaluation (as long as that individual has no financial relationship with the wheelchair supplier) You do have to see the resident before or after the PT/OT evaluation.
You must review the report, indicate your agreement in writing, sign and date the report.

If you do not see the resident after the PT/OT evaluation, the date you sign the report is considered to be the date of completion of the face-to-face physical examination (important also for your billing date of service).
Power Wheelchairs and Power Operated Vehicles

- Record your visit and mobility evaluation in your usual medical record-keeping format. Suppliers oftentimes provide forms for you to complete.......giving you the impression these are sufficient to document your face-to-face examination and evaluation.

- According to CMS auditing experience, many of these forms are not sufficient and your documentation would fail a CMS audit.
What Documentation IS Required???

- Per CMS,...A thorough narrative description of your resident’s current condition, past history, and pertinent physical examination findings that clearly describes their mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs.
The COMPLETE History and Physical typically includes.....

- History of the present condition and past medical history that are relevant to the resident’s mobility needs in the home:
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatments for these symptoms
  - Progression of ambulation difficulty over time
The COMPLETE History and Physical typically includes.....

- History of the present condition and past medical history that are relevant to the resident’s mobility needs in the home:
  - Other diagnoses that may relate to ambulatory problems
  - How far the resident can walk without stopping and with what assistive device, such as a cane or a walker
  - Pace of ambulation
The COMPLETE History and Physical typically includes.....

- History of the present condition and past medical history that are relevant to the resident’s mobility needs in the home:
  - History of falls, including frequency, circumstances leading to falls, and why a walker isn’t sufficient
  - What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn’t sufficient
  - What has changed to now require use of a power mobility device
The COMPLETE History and Physical typically includes.....

- History of the present condition and past medical history that are relevant to the resident’s mobility needs in the home:
  - Ability to use a manual wheelchair
  - Reasons why a power operated vehicle (scooter) would not be sufficient for this resident’s needs in the home
  - Description of the home setting and the ability to perform activities of daily living in the home
Power Wheelchairs and Power Operated Vehicles

- PHYSICAL EXAM-RELEVANT TO THE RESIDENT’S MOBILITY NEEDS
  - HEIGHT AND WEIGHT
  - CARDIOPULMONARY EXAM
  - NEUROLOGICAL EXAM
    - GAIT
    - BALANCE AND COORDINATION
    - IF THE RESIDENT IS CAPABLE OF WALKING, THE REPORT SHOULD INCLUDE DOCUMENTED OBSERVATION OF AMBULATION (WITH USE OF CANE OR WALKER, IF APPROPRIATE)
- MUSCULOSKELETAL EXAM
  - ARM AND LEG STRENGTH AND RANGE OF MOTION
AVOID VAGUE OR SUBJECTIVE DESCRIPTIONS OF THE RESIDENT’S MOBILITY LIMITATIONS...

- “upper extremity weakness”
- “poor endurance”
- “gait instability”
- “weakness”
- “abnormality of gait”
- “difficulty walking”
- “SOB on exertion”
- “pain”
- “fatigue”
- “deconditioned”
Power Wheelchairs and Power Operated Vehicles

- The evaluation should be tailored to the individual resident’s needs
  - History should paint a picture of the resident’s functional abilities and limitations on a typical day.
  - Physical should be focused on the body systems that are responsible for the resident’s ambulatory difficulty or impact the resident’s ambulatory ability.
Power Wheelchairs and Power Operated Vehicles

- Social Security Act defines durable medical equipment as a “home need”
  - Only will be covered if mobility limitation significantly impairs his/her ability to perform ADL’s *WITHIN THE HOME*.
  - In your evaluation, you must clearly delineate your resident’s mobility needs within the home from their needs outside the home.
Power Wheelchairs and Power Operated Vehicles

- **SEVEN ELEMENTS NEEDED ON THE PRESCRIPTION COMPLETED BY THE PHYSICIAN**
  1. Beneficiary’s name
  2. Description of the item that is ordered. May be general (e.g. power operated vehicle, power wheelchair, or power mobility device)
  3. Date of completion of the face-to-face examination
  4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
  5. Length of need
  6. Physician’s signature
  7. Date of physician’s signature
Power Wheelchairs and Power Operated Vehicles

- After the prescription is presented to the DME provider...
  - They will prepare a detailed product description that describes the item being provided including all options and accessories
  - You SHOULD review it, and if you agree, sign and date it, returning it to the supplier
  - If you don’t agree, call supplier and clarify what you want differently
Power Wheelchairs and Power Operated Vehicles

- Medicare allows additional reimbursement to the physician for the additional time and effort that is required to provide this documentation. The code is G0372 and is payable in addition to your E & M visit code.

- Additional information and source for information above can be obtained at www.cms.gov/mcd/overview.asp
Walkers

DOCUMENTATION

- The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home; AND
Walkers

DOCUMENTATION

* The patient is able to safely use the walker
AND
* The functional mobility deficit can be sufficiently resolved by use of a walker

CANES HAVE SAME DOCUMENTATION REQUIREMENT AS WALKERS
Diabetic Shoes

- Must have documented Diabetes Mellitus with appropriate ICD-9 code
Diabetic Shoes

- Must have one or more of the following conditions:
  - History of partial or complete amputation of the foot
  - History of previous foot ulceration
  - History of pre-ulcerative callous formation
  - Peripheral neuropathy with evidence of callous formation
  - Foot deformity
  - Poor circulation
Diabetic Shoes

- You must have treated the patient within the last 6 months under a comprehensive plan of care for his/her diabetes
- You must document the patient needs special shoes (depth shoes) and inserts because of his/her diabetes
- You must certify you have this information in your medical record
Diabetic Shoes

- You must certify you are in good standing with Medicare and a qualified Medicare participating physician
- Document date last seen
Bedside Commodes

- Commodes are covered only when the patient is physically incapable of utilizing regular toilet facilities.
  - The patient is confined to a single room
  - The patient is confined to one level of the home environment and there is no toilet on that level
  - The patient is confined to a home without facilities in the home
Bedside Commodes

- Confinement to a single room means the beneficiary is bedridden, cannot walk with a cane or walker, or cannot use or be wheeled in a wheelchair to access the bathroom.
Bedside Commodes

- Non-Covered Situations
  - Urinary urgency or incontinence issues
  - Slow gait precluding getting to the bathroom on time
  - When beneficiaries are able to walk with or without assistive devices, are able to use a wheelchair in their home, and are able to get to the bathroom
**OXYGEN**

- Patient has a severe lung disease or hypoxia-related symptoms
- Oxygen saturation was the most recent obtained from (Can not be from the ER):
  - Inpatient hospital stay within 2 days of discharge or
  - Outpatient: within 30 days prior to the date of service while the patient was in a chronic, stable state
OXYGEN

- If oxygen saturation equal to or greater that 90%............the patient DOES NOT QUALIFY
OXYGEN

- If oxygen saturation = 89%.......Group II criteria must be met (all of the ones below).
  - saturation =89% at rest or during sleep for at least 5 minutes or during exercise
  - Patient has dependent edema suggesting congestive heart failure or has pulmonary hypertension or cor pulmonale or has erythrocythemia with hematocrit >56%
OXYGEN

- Group II criteria
  - If test done during an exercise test, all of the following must be documented:
    - Test done at rest without oxygen
    - Test done during exercise without oxygen
    - Test done during exercise with oxygen
GROUP I CRITERIA (must meet one of the following criteria)

- At rest oxygen saturation less than or equal to 88%
- While awake oxygen saturation is greater than 89% and during sleep sats are lower than or equal to 88% for at least 5 minutes
- At rest oxygen saturation is greater than 89% on room air BUT during exercise saturation is less than 88% AND oxygen improves hypoxemia
BIPAP/CPAP MACHINES

ORDER SLEEP STUDIES AT A MEDICARE COVERED FACILITY
MoHealthNet’s Pre-certification Process through Cyberaccess

- Nursing facility nurse can get authorization for you
- Nursing staff and physician must register with Cyberaccess
- Immediate authorization. Resident only needs prescription to get equipment
MoHealthNet Imaging Studies

- Affects ALL outpatient and elective/non-emergent CT, MRI, PET scans, Cardiac Imaging, and Ultrasounds
- Require Prior Authorizations
- Medicare Primary, medicaid secondary does not require the process
- Managed by company named *Med Solutions*
MoHealthNet Imaging Studies

- Prior authorization not needed for inpatient and emergency room imaging studies
- Orientation program on Med Solutions website at: www.Medsolutions.com/implementaton
MoHealthNet Imaging Studies

- Can obtain prior authorization on-line 24 hours a day (through Cyberaccess) To sign up for cyberaccess:
  - [www.cyberaccessonlineline.net/cyberaccess/](http://www.cyberaccessonlineline.net/cyberaccess/)
- Can obtain by calling 1-800-392-8030 option 5 from 7 AM to 8 PM
- Authorizations are good for 14 days
Scheduled Drug Prescribing in Long Term Care Facilities

- The nursing facility nurse can be made your agent but you must have a written contract with them giving the authority.
- If no agent made, your office staff can call in the prescriptions to a pharmacy (schedule III meds do not require a nurse call).
- Otherwise, you must send a RX to pharmacy (or call them)-Can have 5 refills.
Narcotic Prescribing in LTC

- Schedule II prescriptions can be made for 90 day supply
- Must have the diagnosis on the prescription
- Must have the fax number faxed to and the fax number faxed from with the time faxed written on the prescription
- Name of Pharmacy must be on the prescription with the name of facility
- Must keep the prescription forever
Narcotic prescribing in LTC

- Nurse practitioners can not prescribe scheduled drugs in LTC (legislation was passed to allow this, however rule-making has not occurred)
Fort Leonard Wood Pharmacy

- Will honor a 3 month supply with 3 refills
- Only honor a one month supply with no refills on schedule III drugs
- No schedule II drugs
Fax requests - Don’t waste your time on the phone
- Engage the nursing facility staff to call on the easy ones
- Part D has to cover any medication prescribed for a 30 day period
- Be specific as to why a certain drug may be inferior due to side effects (e.g. oxybutynin)
MEDICARE PART D
PRIOR AUTHORIZATION
STRATEGIES

- Keep your prior authorization paperwork on file to use again in a year when asked again
- Expensive drugs can be obtained if the alternatives are too risky (biphosphonates vs forteo)
- FYI.............You won’t win the PPI battle!
QUALITY MEASURES NOW AND IN THE FUTURE

- Your compliance will give you a grade on how good of a provider you are
- Started by CMS and now being widely adopted by third party payors
- Eventually.....Pay for Performance????
QUALITY MEASURES FOR DIABETIC RESIDENTS

- BMI CALCULATION (BETWEEN 18.5 AND 24.9)
- BLOOD PRESSURE MONITORING (<130/80)
- LDL CHOLESTEROL (<130 with 1-2 risk factors, <100 with 3 or more risk factors, <70 in some cases)
- A1c (<7.0%)
- STATIN THERAPY (CARDIOPROTECTIVE)
- ASPIRIN THERAPY (CARDIOPROTECTIVE)
QUALITY MEASURES
FOR
DIABETIC RESIDENTS (CONTINUED)

- ACE INHIBITOR/ARB THERAPY (RENAL-PROTECTIVE)
- DILATED EYE EXAM (ANNUALLY, LESS OFTEN IF 3 NORMAL EXAMS, MORE OFTEN IF RETINOPATHY IDENTIFIED)
- COMPREHENSIVE FOOT EXAM ANNUALLY
- MICROALBUMIN ANNUALLY
- CREATININE ANNUALLY
QUALITY MEASURES FOR DIABETIC RESIDENTS (CONTINUED)

- SICK DAY PLAN! (WRITTEN INSTRUCTIONS ON WHAT TO DO IF SICK)
- PNEUMOVAX VACCINATION (ONCE, MAY NEED BOOSTER AT AGE 65 IF RECEIVED MORE THAN 5 YEARS AGO)
- SMOKING (COUNSEL PATIENT TO QUIT AND PROVIDE RESOURCES AS AVAILABLE)
- DEPRESSION SURVEY
- QUALITY OF LIFE SURVEY
Signatures on Requisitions For Clinical Diagnostic Laboratory Tests

- Effective January 1, 2011, a physician’s or a qualified NPP’s signature is required on the requisitions for clinical diagnostic laboratory test paid under the clinical laboratory fee schedule.
- Requisition is defined as the actual paperwork, such as a form, which is provided to a clinical laboratory that identifies the test or tests to be performed for a patient.
Signatures on Requisitions For Clinical Diagnostic Laboratory Tests

- A verbal order for a lab test does not qualify.
- A written order for a lab test does not qualify.
- An electronic signature does not qualify.
- ONLY the paper requisition being signed qualifies for Medicare payment! If not signed, the nursing facility will be responsible for payment to the lab.
Signatures on Requisitions For Clinical Diagnostic Laboratory Tests

- Due to the confusing nature of this new policy, CMS has set the first quarter of 2011 as an educational quarter, providing educational and outreach materials to educate those affected by this policy. After April 1, 2011, CMS will expect requisitions to be signed in order for payment to be made.

- Additional information at:
  - [www.cms.gov/ClinicalLabFeeSched](http://www.cms.gov/ClinicalLabFeeSched)
THANK YOU!!

CONTACT INFORMATION

- Jeffery Kerr D.O. CMD
- ens@fidnet.com