

Home Health & Hospice Medicare A Newsline



Important Information from Cahaba Government Benefit Administrators®, LLC (Cahaba)

November 1, 2009










Vol. 17, No. 2

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at: www.cahabagba.com












The Inside Story

News from CMS

-   News Flash Messages from CMS 1
-   2009 - 2010 Seasonal Influenza (Flu) Resources for Health Care Professionals 3
-   Activation of New Coordination of Benefits Agreement (COBA) Trading Partner Dispute Error Code Within the National Crossover Process 7
-   Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update 9
-  Revised Processing of Osteoporosis Drugs under the Home Health Benefit—**Revised** 12

News from Cahaba

-   Submitting Medicare Secondary Payer (MSP) Claims/Adjustments 13
-   Reminder of Timely Claim Filing Requirements 15
-   Updated Frequently Asked Questions (FAQs) for Top Inquiries 17
-   System and Provider Contact Center Availability for November 17
-  Updated Hospice Quick Reference Tools 18
- Cahaba Learning Corner** 19

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Key for Icons:



Home Health Providers



Hospice Providers

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News Flash Messages from CMS for Home Health and Hospice Providers

**H1N1 Influenza Immunizations**

Medicare will cover immunizations for H1N1 influenza also called the “swine flu”. There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. H1N1 influenza vaccine is currently under production and will be available in the fall of 2009. For more information, go to <http://www.cms.hhs.gov/H1N1> on the CMS Web site.

**Flu Season is Upon Us!**

CMS encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get seasonal flu shots. Flu shots are their best defense against combating flu this season. And don't forget—health care workers also need to protect themselves.

Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient as a Part B benefit. No deductible or copayment/coinsurance applies. Note that the influenza vaccine is NOT a Part D covered drug.

For more information about Medicare's coverage of the seasonal influenza vaccine and its administration, as well as related educational resources for health care professionals, please go to http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.

For information on Medicare policies related to H1N1 influenza, please go to <http://www.cms.hhs.gov/H1N1/> on the CMS Web site.



HIPAA Versions 5010 and D.0 Conference Call Information Available

On June 9, 2009, the Centers for Medicare & Medicaid Services (CMS) conducted a national provider conference call on the HIPAA Versions 5010 and D.0. You can view the presentation, transcript and listen to the audio file from that call by accessing http://www.cms.hhs.gov/Versions5010andD0/Downloads/6-9-2009_National_Provider_Call.pdf on the CMS Web site.



HIPAA 5010 Special Edition MLN Matters Article

A HIPAA 5010 Special Edition MLN Matters provider education article is now available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf> on the CMS Web site. This Special Edition article alerts providers regarding the implementation of HIPAA 5010 which presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to their electronic inquiries and outlines how providers need to plan for implementation of these changes.



ICD-10-CM/PCS Medicare Learning Network Products

The publication titled *ICD-10-CM/PCS Myths & Facts* (June 2009), which presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System, is now available in both downloadable and print formats from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network .

The revised publication titled *ICD-10-CM/PCS: An Introduction Fact Sheet* (August 2009), which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in print format from the CMS **Medicare Learning Network**.

Visit <http://www.cms.hhs.gov/MLNProducts/> to find this and several other ICD-10 products. Scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page” for print formats or click on “MLN Publications” for downloadable versions.



2009 - 2010 Seasonal Influenza (Flu) Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition (SE) Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters® Number: SE0926

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

Note from Cahaba: Hospices bill and are reimbursed for the flu vaccine and the administration under Medicare Part B by the Part B carrier/Part A/B Medicare administrative contractor (A/B MAC).

Provider Action Needed

- Keep this Special Edition MLN Matters article and refer to it throughout the 2009 - 2010 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction

Historically, the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

CMS reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu and pneumococcal immunizations. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Prevention is Key to Public Health!

While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, this year, due to planning for H1N1 flu, Medicare will make payment for seasonal flu vaccines that are provided earlier in the year than usual.

Seasonal flu vaccines can still help protect Medicare beneficiaries who get the vaccine in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational Products for Health Care Professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

1. MLN Matters Seasonal Influenza Articles

- **MM6608:** Influenza Vaccine Payment Allowances – Annual Update for 2009-2010 Season at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6608.pdf> on the CMS Web site.
- **MM6539:** 2009 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6539.pdf> on the CMS Web site.
- **MM5511:** Update to Medicare Claims Processing Manual, Chapter 18, §10 for Part B Influenza Billing at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf> on the CMS Web site. **Note from Cahaba:** This information is specific to providers that bill using the CMS-1500 claim form, which would impact hospices that provide flu shots.
- **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf> on the CMS Web site.
- **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf> on the CMS Web site.

2. MLN Seasonal Influenza Related Products for Health Care Professionals

- **Quick Reference Information: Medicare Part B Immunization Billing** - This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. This product is available in print and as a downloadable PDF at http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS Web site.

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Third Edition** - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. The guide is available as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS Web site.
- **Medicare Preventive Services Adult Immunizations Brochure** - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. This brochure is available as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf on the CMS Web site.
- **Quick Reference Information: Medicare Preventive Services** - This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes seasonal influenza, pneumococcal, and hepatitis B vaccines. This chart is available in print or as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf on the CMS Web site.
- **Medicare Preventive Services Bookmark** - This bookmark lists the preventive services and screenings covered by Medicare (including seasonal influenza) and serves as a handy reminder for health care professionals of the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. This bookmark is available in print or as a downloadable PDF file at <http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf> on the CMS Web site.
- **MLN Preventive Services Educational Products Web Page** - This Medicare Learning Network (MLN) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page (http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp) for easy access.

3. Other CMS Resources

- **CMS Adult Immunizations Web Page** is at <http://www.cms.hhs.gov/AdultImmunizations> on the CMS Web site.
- **CMS Frequently Asked Questions** are available at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi on the CMS Web site.
- **Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations** available at <http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf> on the CMS Web site.
- **Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services** available at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS Web site.

- **Medicare Part B Drug Average Sales Price Payment Amounts** Influenza and Pneumococcal Vaccines Pricing found at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp on the CMS Web site.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009 – 2010 flu season:

- **Advisory Committee on Immunization Practices** are at <http://www.cdc.gov/vaccines/recs/acip/default.htm> on the Internet.
- **American Lung Association’s Influenza (Flu) Center** is at <http://www.lungusa.org> on the Internet. This Web site provides a flu clinic locator at <http://www.flucliniclocator.org> on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- **Other sites with helpful information include:**
- **Centers for Disease Control and Prevention** - <http://www.cdc.gov/flu/>;
- **Flu.gov** - <http://www.flu.gov/>;
- **Food and Drug Administration** - <http://www.fda.gov/>;
- **Immunization Action Coalition** - <http://www.immunize.org/>;
- **Immunization: Supporting a Healthy Life Throughout the Lifespan** - <http://www.nfid.org/pdf/publications/naiaw08.pdf>;
- **Indian Health Services** - <http://www.ihs.gov/>;
- **National Alliance for Hispanic Health** - <http://www.hispanichealth.org/>;
- **National Foundation For Infectious Diseases** - <http://www.nfid.org/influenza/>;
- **National Library of Medicine and NIH Medline Plus** - <http://www.nlm.nih.gov/medlineplus/immunization.html>;
- **National Network for Immunization Information** - <http://www.immunizationinfo.org/>;
- **National Vaccine Program** - <http://www.hhs.gov/nvpo/>;
- **Office of Disease Prevention and Promotion** - <http://odphp.osophs.dhhs.gov/>;
- **Partnership for Prevention** - <http://www.prevent.org/>; and
- **World Health Organization** - <http://www.who.int/en> on the Internet.

Beneficiary Information

For information to share with your Medicare patients, please visit <http://www.medicare.gov> on the Internet. Important information about H1N1:

Medicare will cover immunizations for H1N1 influenza, also called the “swine flu.” There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. H1N1 influenza vaccine is currently under production and will be available in the fall of 2009. For more information, go to <http://www.cms.hhs.gov/H1N1> on the CMS Web site.

Disclaimer

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Activation of New Coordination of Benefits Agreement (COBA) Trading Partner Dispute Error Code Within the National Crossover Process

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters® Number: MM6640

Related CR Release Date: September 25, 2009

Related CR Transmittal #: R562OTN

Related Change Request (CR) #: 6640

Effective Date: October 26, 2009

Implementation Date: October 26, 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 6640, which conveys a new COBA trading partner dispute error code that the Coordination of Benefits Contractor (COBC) will return to Medicare contractors when certain claims are not accepted by supplemental payers. Billing staff should be aware of this change.

Background

The COBC consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. CMS developed and further refined the COBC Detailed Error Report process through the issuance of CR 3709 (See Transmittals 474, dated February 11, 2005, at <http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf> on the CMS Web site) and CR 5472 (See Transmittal 1189 dated February 28, 2007, at <http://www.cms.hhs.gov/Transmittals/Downloads/R1189CP.pdf> on the CMS Web site).

Under the COBC Detailed Error Report process, the COBC reports to Medicare contractors, via a standard Detailed Error Report layout, any of the following error conditions that resulted in their claims not being crossed over:

- Incoming flat file contained structural problems (“111” flat file errors);
- Incoming flat file contained claims with Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) compliance errors (“222” errors); and
- The COBA trading partner rejected the contractors’ claims (“333” trading partner dispute errors).

NOTE: Crossover is the transfer of processed claim data from Medicare operations to commercial insurance companies that sell supplemental insurance benefits to Medicare beneficiaries and to Medicaid (or state) agencies.

Depending upon the error percentage encountered in association with errored claims, Medicare contractors then, after five (5) business days, automatically generate special provider notification letters informing the affected physician/supplier/provider that the beneficiary's claim(s) cannot be crossed over.

In earlier instructions CMS directed Medicare contractors to suppress creation of their standard provider notification letters when they receive any of the following "333" dispute reason codes via the COBC Detailed Error Reports:

- 00100—duplicate claim;
- 000110—duplicate claim within the same ISA-IEA loop; and
- 000120—duplicate claim within the same ST-SE loop.

CMS made this decision primarily for two reasons:

1. It was believed that these particular error conditions were out of the control of the billing provider; and
2. It would be futile for the provider to bill the claims to the COBA trading partner outside the crossover process given that the entity had already received the claim, as witnessed by its lodging of a dispute on the basis of duplicate claim receipt.

Currently, the only in-use "333" dispute codes that will trigger provider notification letters are the following:

- 000200—Claim for provider ID/state should have been excluded;
- 000300—Beneficiary not on eligibility-file;
- 000500—Incorrect claim count;
- 000600—Claim does not meet selection criteria;
- 000700—HIPAA error; and
- 009999—Other.

Through CR 6640, the COBC will activate dispute reason code 000400 (previously reserved for future use) as a new "333" trading partner dispute code. As a result of this action, the COBC will:

1. Transmit error code 000400 to Medicare contractor when indicated via the COBC Detailed Error Report; and
2. Include within the error description field on the COBC Detailed Error Report the following standard message: "No provider agreement with Medicaid/other payer; claims crossover not possible."

Also, as a result of CR 6640, all Medicare contractors will generate error code 000400 when received via their COBC Detailed Error Report with accompanying error message on their outgoing notification letters to providers, physicians, or suppliers. As indicated in CR 6640, upon receipt of the contractor-generated special letters, affected providers, physicians, or suppliers may wish to contact their patient's indicated supplemental payer to determine next steps.

Additional Information

The official instruction, CR 6640, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R562OTN.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Phone Us” to call the Provider Contact Center.

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Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters® Number: MM6604

Related Change Request (CR) #: 6604

Related CR Release Date: August 28, 2009

Effective Date: October 1, 2009

Related CR Transmittal #: R1804CP

Implementation Date: October 5, 2009

Provider Types Affected

This article is for physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare administrative contractors (MACs), durable medical equipment Medicare administrative contractors (DME MACs)) for services.

Provider Action Needed

CR 6604, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2009. Be sure billing staff are aware of these changes.

Background

For Medicare, the reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by CMS, and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month.

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are posted at <http://www.wpc-edi.com/Codes> on the Internet. The lists following the end of the “Additional Information” section of this article summarize the latest changes to these lists, as announced in CR 6604.

Additional Information

To see the official instruction (CR 6604) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1804CP.pdf> on the CMS Web site.

For additional information about Remittance Advice, please refer to “Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers” at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Phone Us” to call the Provider Contact Center.

New Codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	1/1/2010

Modified Codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 04/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. This change to be effective 04/01/2010: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
54	Multiple physicians/assistants are not covered in this case. This change to be effective 04/01/2010: Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
55	Procedure/treatment is deemed experimental/investigational by the payer. This change to be effective 04/01/2010: Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. This change to be effective 04/01/2010: Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present. 4/1/2010	
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	4/1/2010

	This change to be effective 04/01/2010: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 04/01/2010: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
90	Ingredient cost adjustment. This change to be effective 04/01/2010: Ingredient cost adjustment. Note: To be used for pharmaceuticals only.	4/1/2010

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
156 *	Flexible spending account payments. Note: Use code 187.	10/1/2009

* Also included in CR 6453

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N519	Invalid combination of HCPCS modifiers.	NO
N520	Alert: Payment made from a Consumer Spending Account.	NO

Modified Codes – RARC:

None

Deactivated Codes – RARC

None

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Revised Processing of Osteoporosis Drugs under the Home Health Benefit—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network (MLN) Matters* article entitled, “Revised Processing of Osteoporosis Drugs under the Home Health Benefit,” which was published in the September 1, 2009, *Home Health & Hospice Medicare A Newsline*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at:

<http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters® Number: MM6512 Revised

Related CR Release Date: September 18, 2009

Related CR Transmittal #: R1818CP

Related Change Request (CR) #: 6512

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Note: This article was revised on September 21, 2009, to reflect revisions made to CR 6512, which was re-issued on September 18. The CR Release Date, Transmittal Number (see above), and the Web address for accessing CR 6512 were revised. All other information is the same.

Provider Types Affected

Home health agencies (HHAs) submitting claims to Medicare contractors (regional home health intermediaries (RHHI), fiscal intermediaries (FI) and Medicare administrative contractors (MACs)) for injectable osteoporosis drugs provided to Medicare beneficiaries are affected.

Provider Action Needed

HHAs are reminded that the current criteria for coverage of injectable osteoporosis drugs must be met when submitting claims for these drugs. There is no change in these criteria. However, this article explains that the date of service on claims submitted for covered osteoporosis drugs must fall within the start and end dates of an existing home health prospective payment system (PPS) episode. Please inform your billing staffs of this requirement.

Background

Medicare covers injectable osteoporosis drugs if certain criteria are met. These criteria include:

- Eligibility for coverage of home health services;
- Physician certification that the individual sustained a bone fracture related to post-menopausal osteoporosis; and
- Physician certification that the female patient is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

Currently, the second and third criteria are enforced to the extent possible through Medicare systems by edits that require that the beneficiary is female and that the diagnosis code 733.01 (post-menopausal osteoporosis) is present. However, the first criterion that the beneficiary must be covered under the home health benefit is only partially enforced. If an osteoporosis claim is received and a home health episode of care is on file, Medicare requires that the provider number of the HHA submitting the osteoporosis claim

must be the same as the provider number on the episode record. CR 6512 revises the Medicare systems to fully enforce this criterion by requiring that the date of service for an injectable osteoporosis drug on a home health claim falls within the start and end dates of an existing home health episode if the claim contains:

- Type of bill 34x;
- Healthcare Common Procedure Coding Systems (HCPCS) codes J0630, J3110, or J3490; and
- Covered charges corresponding to these HCPCS codes.

Claims not meeting the criteria for coverage will be rejected with the following messages: MSN message 6.5, “Medicare cannot pay for this injection because one or more requirements for coverage were not met;” and claim adjustment reason code 177, “Patient has not met the required eligibility requirements.”

Additional Information

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Phone Us” to call the Provider Contact Center.

The official instruction, CR 6512, issued to your Medicare RHHI, FI, and/or MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1818CP.pdf> on the CMS Web site.

Disclaimer This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

News from Cahaba for Home Health and Hospice Providers



Submitting Medicare Secondary Payer (MSP) Claims/Adjustments

Cahaba previously informed providers via e-mail messages sent September 30 and October 9, 2009, of the change in submitting MSP claims and adjustments. As indicated in Change Request (CR) 6426, Medicare secondary payer (MSP) claims and MSP adjustments, submitted on or after October 5, 2009, must be submitted using the American National Standard Institute (ANSI) ASC X12N 837 4010-A1 format. The Centers for Medicare & Medicaid Services (CMS) requires that CAS segments be submitted on MSP claims and adjustments; however, CAS segments are not utilized when MSP claims and adjustments are entered directly into the Fiscal Intermediary Standard System (FISS) via Direct Data Entry (DDE). As a result, claims and adjustments with MSP information must be submitted using the 837 format. The new reason code 31265, which is associated with this requirement, will display when an MSP claim or adjustment is entered or corrected via the FISS DDE. The following provides additional clarification of this requirement.

- **PC-Ace Pro32**

If your vendor's software program does not allow you to send MSP claims, you can use the free Microsoft Windows based claims submission software PC-Ace Pro32 v. 2.14. PC-Ace Pro32 has the capability of sending MSP claims and adjustments electronically in the 837 format with the necessary CAS segments

needed to meet this requirement. This is also a great option if you do not use a vendor's software, clearinghouse, or billing service to submit claims or adjustments to Medicare. Refer to the "EDI Software Downloads / Instructions" Web page at <https://www.cahabagba.com/rhhi/edi/software.htm> for additional information. To request PC-Ace Pro32, complete the "EDI Services Enrollment Update Application" at: http://www.cahabagba.com/rhhi/forms/edi_enrollchange.pdf

- **Correcting MSP Claims and Adjustments**

While this change affects the initial submission of MSP claims and adjustments, it also impacts providers when correcting MSP claims or adjustments that are in the return to provider (RTP) file (status/location T B9997). Even if an MSP claim/adjustment is originally submitted electronically using the 837 format, when it is corrected from RTP, it is considered a new claim or adjustment being submitted via FISS DDE. This means that all MSP claims and adjustments that are in RTP and are corrected by accessing the "Claim and Attachments Correction Menu" will receive reason code 31265.

As a result, MSP claims and adjustments that are in RTP status/location T B9997 must be resubmitted electronically using the 837 format or on a hardcopy (paper) CMS-1450 (UB-04) claim form with the correct information. Providers should be aware that Medicare claims may encounter different edits while processing and claims may need correction more than one time, and for multiple reasons. Therefore, providers should verify that all required claim data is present and that the information is complete and correct prior to resubmitting claims. Information about required claim data on home health and hospice claims is available on the [Home Health Claims Filing](#) and [Hospice Claims Filing](#) Web pages. The [Medicare Secondary Payer \(MSP\) Billing](#) quick reference tool contains the required MSP data submitted on claims depending on the type of insurance that is primary to Medicare.

Since claims with MSP information can no longer be corrected, but must be resubmitted, Cahaba encourages you to suppress the view of claims in the RTP file so that they do not get corrected accidentally. Instructions for suppressing the view of claims are available in the "[Claims Correction Menu](#)" section of the *FISS Reference Guide*.

- **Submitting Hardcopy (Paper) Claims**

Because of the Medicare requirement for mandatory electronic submission of Medicare claims, (CMS Pub. 100-04, Ch. 24, §90), which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf>, providers are not allowed to submit original claims on paper, unless you meet the small provider exception or one of the other exceptions noted in §90.2. Therefore, if you do not meet these exceptions, you must use the following process when submitting a hardcopy (paper) claim.

- Submit a claim via FISS DDE showing Medicare as the primary payer. This will result in the claim being rejected.
 - Please be aware that claims may reject to FISS status/location (S/LOC) R B75XX or R B9997. As we informed you in an email message sent on August 20, 2009, claims that reject to an R B75XX S/LOC will remain there for at least 75 days. Providers should not submit an adjustment to a rejected claim until it moves to a finalized R B9997 S/LOC.
- Submit a hardcopy (paper) adjustment to the rejected claim and include all the information regarding payment from the primary payer source. This includes the amount received as payment, the amount the provider is obligated to accept as payment in full, and any deductible or coinsurance amounts that were applied. For additional information about submitting MSP information, refer to Cahaba's Medicare Secondary Payer (MSP) Web page at <https://www.cahabagba.com/rhhi/claims/msp/index.htm>

Hardcopy (paper) claims and adjustment can be mailed to the following address:

Cahaba GBA
Medicare A Claims
P.O. Box 9169
Des Moines, IA 50306-9169

For additional information, you can find the official instruction (CR 6426) for this requirement by visiting <http://www.cms.hhs.gov/transmittals/downloads/R70MSP.pdf> on the CMS Web site. You will find the updated *Medicare Secondary Payer (MSP) Manual*, (CMS Pub 100-05) Ch. 5 (Contractor Prepayment Processing Requirements), §40.7.3.2 (Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format) as an attachment to that CR. The related *Medicare Learning Network (MLN)* article is located at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6426.pdf>



Reminder of Timely Claim Filing Requirements

It is that time of year! Please review your billing records to ensure all services are billed within the timely claim filing requirements. Remember, **all** Medicare billing transactions are subject to the timely filing requirements. This includes new billing transactions, corrections (return to provider (RTP)) and adjustment (type of bill XX7) requests. In addition, if you cancel a claim (type of bill XX8) with dates of service that are outside of the timely filing parameters, any resubmitted claim will be subject to the timely filing requirements, and will be rejected if untimely. Please review the following requirements and submit your older claims now.

Timely Claim Filing Requirements

Claims for services provided in the first three quarters of a calendar year (January—September) are considered timely if received by December 31 of the year following the service year. Claims for services provided in the fourth quarter (October—December) of a calendar year have an additional year. **All claims with dates of service between October 1, 2007, and September 30, 2008, must be filed (received) by December 31, 2009. Note that a new receipt date is assigned to a claim when the claim is corrected and moved out of the RTP file.** If the receipt date is outside the timely filing standards, the claim may reject (status/location (S/LOC) R B9997) and no Medicare payment will be made. Untimely claims may also finalize in S/LOC P B9997 with an “R” in the No Pay Code (NPC) field.

Hospice and home health agencies should also be aware that prior to the submission and processing of their claims, a ***processed (S/LOC P B9997)*** Notice of Election (NOE) or Request for Anticipated Payment (RAP) may be required, so as not to create billing errors. It is, therefore, imperative that providers allow enough time for these billing transactions to process prior to submitting the claim for the hospice billing period or home health episode of care.

Instructions for Timely Filing for Home Health Claims

Under the Home Health Prospective Payment System (HH PPS), claims represent an episode of care of up to 60 calendar days. Therefore, episodes may easily span from the third quarter (July, August, and

September) into the fourth quarter (October, November, and December) of a given calendar year. Under this situation, the Fiscal Intermediary Standard System (FISS) will compare the receipt date of a home health (HH) claim to the latest line item service date to determine whether the HH claim is filed timely. For example, a HH claim with dates of service September 10, 2008, to November 8, 2008, with the last line item date of service (LIDOS) of September 29, 2008, would be considered timely if submitted by December 31, 2009. Refer to the following chart for additional guidance.

Date of Service	Last LIDOS	Submit by:
09/10/2007 – 11/8/2007	10/29/2007	12/31/2009
09/10/2008 – 11/8/2008	09/29/2008	12/31/2009
09/10/2008 – 11/8/2008	10/29/2008	12/31/2010
09/10/2009 – 11/8/2009	09/29/2009	12/31/2010
09/10/2009 – 11/8/2009	10/29/2009	12/31/2011

Untimely Filing Exceptions

Cahaba receives many requests from home health and hospice providers to waive timely filing guidelines. Home health and hospice providers should be aware that Medicare regulations allow an exception to timely filing in cases where a Medicare administrative error has occurred. These would include such situations as:

- The beneficiary’s Part A or Part B benefits were not established timely;
- The Social Security Administration (SSA) failed to inform the beneficiary of their entitlement to Medicare benefits;
- Information needed by the provider to file the claim was not provided by Medicare, or the intermediary.

The following circumstances are examples of situations which ***do not*** constitute waiving Medicare timely filing guidelines:

- No knowledge by provider of Medicare coverage, billing, claim submission, or timely filing requirements;
- Provider inability to gather or review medical documentation prior to claim submission;
- Medicare is the secondary payer; however, no MSP claim was submitted to Medicare. It is later determined that primary insurance was not valid or in effect, the primary payment is recouped, and the provider now needs to file a Medicare claim;
- Inexperience of or errors by provider clinical or billing staff;
- NOE, RAP or claim in RTP when timely filing expired.

For additional information about timely filing requirements, refer to the Centers for Medicare & Medicaid Services (CMS), [Medicare Claims Processing Manual, \(CMS Pub. 100-04\) Ch. 1](#), §70.





Updated Frequently Asked Questions (FAQs) for Top Inquiries

Based on a review of the topics most asked during July through September 2009, the Frequently Asked Questions (FAQs) for the top inquiries received in Cahaba's Home Health & Hospice Provider Call Center (PCC) have been updated. Providers should attempt to resolve their Medicare questions using the FAQs and "Resources for the Most Common Medicare Part A Provider Questions" Web page (http://www.cahabagba.com/rhhi/claims/provider_resources.htm) prior to calling the Customer Service Representatives (CSRs). Please ensure that your staff is aware that Cahaba CSRs should be contacted only to answer questions that cannot be resolved through self-service options such as the FAQs, "Resources" Web page and other materials posted to the Cahaba Web site, the Interactive Voice Response (IVR) system, the Cahaba ListServ, and Internet based educational offerings. In the *Medicare Contractor Beneficiary and Provider Communications Manual* (Pub. 100-09, Ch. 6), the Centers for Medicare & Medicaid Services (CMS) recommends that intermediaries, like Cahaba, require providers to use these tools in order to successfully manage the volume of their provider inquiries.

The updated home health and hospice (HH+H) FAQs can be accessed on our Web site using the following link: <http://www.cahabagba.com/faq.htm>

Providers without Internet access may request a copy of the FAQs by calling the Provider Outreach and Education department at 515-471-7335.



System and Provider Contact Center Availability for November

To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) encourages ongoing training of Customer Service Representatives and allows the provider contact centers to close on Federal holidays to conduct training sessions. Therefore, **Wednesday, November 11, 2009**, (Veterans Day), the Home Health and Hospice Provider Contact Center (1-877-299-4500 and 1-866-539-5592) will not be available. The Interactive Voice Response (IVR) unit will be available for providers to check beneficiary eligibility or the status of claims.

System Availability

The Fiscal Intermediary Standard System (FISS) will be available **Wednesday, November 11, 2009**, for providers to check beneficiary eligibility or the status of claims as well as submit and correct claims and receive reports electronically. However, **FISS will not cycle during the evening of November 11, 2009**. This means that claims will not be sent to the Common Working File (CWF) during the nightly cycle, and Medicare Remittance Advices (RAs), Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on November 11, 2009.

Thanksgiving Holiday

While we celebrate the Thanksgiving holiday with our families, our office will be closed on Thursday and Friday, November 26 and 27, 2009. Our data center has informed us that FISS will not be available on Thursday, November 26, 2009. However, FISS will be available on Friday, November 27, 2009. In addition, FISS will not cycle, which means that claims will not be sent to the Common Working File (CWF)

either night. Medicare Remittance Advices (RAs), Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced on November 26 and 27. As a reminder, the **Interactive Voice Response (IVR) unit will be available to providers to check beneficiary eligibility or the status of claims.**

News from Cahaba for Hospice Providers



Updated Hospice Quick Reference Tools

The hospice quick reference tools, “[Hospice Medicare Billing Code Sheet](#)” and “[Hospice References](#)” have been updated to reflect the new reporting requirements issued in Change Request (CR) 6440. This CR mandates hospice providers to report additional detail for visits with appropriate revenue codes and HCPCS codes. The reporting requirements in this CR are optional, effective October 1, 2009, but will become mandatory effective January 1, 2010. These tools and more are available on the [Hospice Quick Reference Tools](#) Web page. Please be sure that your billing staff is aware of these valuable resources.

November 2009 Education Events

To register for educational events, go to the "[Calendar of Educational Events](#)" page on our Web site. Select the event title for registration instructions.

➤ **["FISS 301 for Home Health: Did I Do That?!"](#) Webinar**

Date: November 3, 2009

Time: 12:00 to 2:00 p.m. Central Time (CT)

Registration Deadline: October 29, 2009

Intended Audience: Home health agency staff, including administrators, CFOs, billing and quality assurance staff.

Description: This Webinar provides information that will help you identify and correct home health Requests for Anticipated Payment (RAPs) and final claims that have gone to the return to provider (RTP) file. Common home health billing errors and resources for avoiding them will also be presented.

➤ **["FISS 301 for Hospice: Did I Do That?!"](#) Webinar**

Date: November 5, 2009

Time: 12:00 to 2:00 p.m. Central Time (CT)

Registration Deadline: November 2, 2009

Intended Audience: Hospice agency staff, including administrators, CFOs, billing and quality assurance staff.

Description: This Webinar provides information that will help you identify and correct notices of election (NOEs) and claims that have gone to the return to provider (RTP) file. An overview of the common hospice billing errors and resources for avoiding them will also be presented.

➤ **Utah Hospice & Palliative Care Organization Annual Convention**

Date: November 9, 2009

Description: This event is sponsored by the Utah Hospice & Palliative Care Organization (UHPCO) and will be held at the Salt Lake Community College in Sandy, Utah. For more information, or to register for this event, please contact UHPCO at 801-582-2245, via fax at 801-487-6424, or via their Web site at: www.utahhospice.org/

➤ **Regional Roundtable for Hospice Caregivers**

Date: November 11, 2009

Description: This in-person event is sponsored by the Healthy Appalachia Institute and the Hospice & Palliative Care of Virginia, and will be held at the Southwest Virginia Higher Education Center in Abingdon, VA. For more information, or to register, please call 1-276-328-0289 or email em2vx@uvawise.edu

➤ **West Virginia Council of Home Care Agencies (WVCHCA) Annual Meeting**

Date: November 11, 2009

Description: This in-person event is sponsored by WVCHCA and will be held at the Lakeview Resort in Morgantown, WV. Educational workshops for both clinical and billing staff will be available. For more information about this event or to register, please contact Laura Friend at WVCHCA by calling (304) 758-4312 or email at wvhomecare@hughes.net

➤ **“Resolving to Roster Bill: Lunch & Learn” Webinar**

Date: November 17, 2009

Time: 12:00 to 1:00 p.m. Central Time (CT)

Registration Deadline: November 12, 2009

Intended Audience: Home health agency billing staff.

Description: This Webinar will discuss how to appropriately submit roster bills containing influenza and pneumococcal pneumonia vaccine and administration charges. In addition, the Fiscal Intermediary Standard System (FISS) roster billing screen and the required data elements for claims entry using this screen will also be discussed.

➤ **“FISS 401: Claim Makeovers” Webinar**

Date: November 19, 2009

Time: 12:00 to 2:00 p.m. Central Time (CT)

Registration Deadline: November 16, 2009

Intended Audience: Home health and hospice agency billing staff.

Description: This Webinar will discuss how to use the Fiscal Intermediary Standard System (FISS) to adjust claims and cancel claims.

➤ **“FISS 501: The Big Picture” Webinar**

Date: November 24, 2009

Time: 12:00 to 2:00 p.m. Central Time (CT)

Registration Deadline: November 19, 2009

Intended Audience: Home health and hospice agency billing staff and administrators.

Description: This Webinar will focus on the path of a claim once it is submitted into the Fiscal Intermediary Standard System (FISS). A big picture of Medicare claims processing will be provided to give staff a basic understanding of claim submission and claim correction.

- **“Online Courses”** are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone.

Course Title	Description
Adjusting and Canceling Claims	Learn how to adjust or cancel claims.
Advanced Hospice Billing	Learn about advanced hospice billing topics.
Appeals Process	Learn about the Medicare appeals process.
Basics of ICD-9-CM Coding for Home Health Clinicians	Learn the basics ICD-9-CM coding.
Beginner Hospice Billing	Learn the basics of hospice billing.
Beginner Home Health Billing	Learn the basics of home health billing.
CERT (Comprehensive Error Rate Test)	Learn about the CERT Program.
Checking Claims Status	Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.
Comprehending Medicare Claims Processing	Learn about Medicare claims processing.
Medicare Coding (Insight into)	Learn the basics about Medicare coding.
Medicare Cost Report (Introduction to)	Learn the basics about the Medicare Cost Report
Medical Review (Getting a view of)	Learn the basics of the Medical review process.
Medicare Secondary Payer	Learn the basics of Medicare Secondary Payer.
Overview of Medicare	Learn the basics about the Medicare program.

➤ **“Online Courses”** (Continued)

Course Title	Description
Provider Enrollment	Learn about provider enrollment and how to apply.
Verifying Beneficiary Eligibility	Learn how to identify various eligibility information by using ELGA and ELGH.

Please note these courses were designed specifically for providers served by Cahaba. You can find additional national courses under the [Medicare Learning Network](#).



- **Didn't find what you were looking for?** [Visit our Web site](#)—it provides a variety of valuable information and is continuously updated.



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