

# HEALTH LAW

## Update

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### The Final 2010 Medicare Physician Fee Schedule: Highlights

November 24, 2009

On October 30, 2009, the Centers for Medicare & Medicaid Services ("CMS") released the final 2010 Medicare Physician Fee Schedule (the "2010 MPFS Final Rule") containing changes to policies and payment rates for services furnished by physicians and non-physician practitioners who are paid under the Medicare Physician Fee Schedule ("MPFS").<sup>1</sup> The 2010 MPFS Final Rule, effective for calendar year 2010 ("CY 2010"), finalizes most of the payment updates, policies, and incentive programs proposed by CMS this past July.<sup>2</sup> This *Health Law Update* highlights certain of these changes.

#### **Sustainable Growth Rate Modification, Imaging Cuts, and Other Payment Updates**

*Sustainable Growth Rate.* Under current law, CMS is required to adjust annually the payment rates under the MPFS using a formula based, in part, on the application of the sustainable growth rate ("SGR") that was adopted in the Balanced Budget Act of 1997.<sup>3</sup> The intended purpose of the SGR is to limit growth in Medicare expenditures for physicians' services. The application of the SGR has resulted in annual reductions to the reimbursement rates under the MPFS since 2002. For CY 2010, the SGR will reduce the conversion factor for services furnished on or after January 1, 2010 by 21.2%, less than the 21.5% reduction projected by CMS in July.<sup>4</sup> CMS attributes the difference to the agency's use of the most recently available data on CMS spending for physicians' services.

<sup>1</sup> The 2010 MPFS Final Rule is currently available at [http://www.federalregister.gov/OFRUpload/OFRData/2009-26502\\_PI.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf) (hereinafter cited as CMS-1413-FC). The final rule with comment is scheduled to appear in the November 25, 2009 Federal Register. CMS will accept comments on designated provisions of the rule until December 29, 2009 and will respond to all comments at a later date. Unless otherwise specified, the new payment rates and policies will apply to services furnished to Medicare beneficiaries on or after January 1, 2010. See CMS-1413-FC at 2-4.

<sup>2</sup> A summary of some of the changes proposed by CMS in July can be found in our *Health Law Alert* entitled "The Proposed 2010 Medicare Physician Fee Schedule: Imaging Takes Another Hit; and Electronic Health Records are Everybody's New Best Friend," available at <http://www.bassberry.com/files/Publication/d740acbb-7def-4a30-86e1-15335cfa90f7/Presentation/PublicationAttachment/a7cc706e-98a5-4d63-aa1c-0629494358cd/HC%20Alert.pdf>.

<sup>3</sup> See CMS, *Press Release: CMS Announces Payment, Policy Change for Physicians' Services to Medicare Beneficiaries in 2010*.

<sup>4</sup> See CMS-1413-FC at 1, 1068. See also 74 Fed. Reg. 33520, 33651 (July 13, 2009).

In each of the past several years, Congress has passed legislation to avert reductions to the MPFS that would otherwise have been required under the SGR. On November 19, 2009, the U.S. House of Representatives passed legislation that would cancel the scheduled 21.2% reduction and increase reimbursement under the MPFS for CY 2010 by 1.2%.<sup>5</sup> The House bill would also replace the SGR with a new formula that would (a) remove from spending targets items not paid directly to practitioners (*e.g.*, drugs and laboratory services), (b) allow the volume of most services to grow at an annual rate equal to the gross domestic product ("GDP") plus 1%, and (c) allow the volume of primary and preventive care services to grow at an annual rate equal to the GDP plus 2%.<sup>6</sup> The bill will soon be considered by the Senate, where an attempt to repeal the SGR stalled earlier this year. The healthcare reform bill recently proffered by the Senate Finance Committee also includes proposals to eliminate the SGR, increase reimbursement under the MPFS by 0.5% for CY 2010, and freeze payments under the MPFS for ten years thereafter.<sup>7</sup>

*Physician-Administered Drugs Eliminated from Future SGR Calculations.* Historically, the costs of physician-administered drugs, which are not paid under the MPFS, have been included in CMS's calculations of actual and target expenditures under the SGR. These costs have accounted for an increasingly disproportionate amount of the growth in spending on physicians' services since the inception of the SGR, exacerbating the resulting annual MPFS reimbursement rate reductions.<sup>8</sup> In the 2010 MPFS Final Rule, CMS finalizes its proposal to remove physician-administered drugs from the SGR expenditure calculations. The change would apply retrospectively for each year back to the 1996/97 base year and prospectively to future SGR calculations. The new rule would reduce the annual discrepancies between actual and target expenditures calculated under the SGR, effectively reducing the cumulative MPFS reimbursement rate reductions required under the old formula through CY 2009. CMS notes, however, that the 21.2% reduction for services furnished on or after January 1, 2010 would not be affected by the change since the stated rate takes into account the effect of the resulting reductions calculated for previous years under the new formula. Going forward, the change would reduce the number of years in which physicians are projected to continue to experience reductions in the MPFS reimbursement rates as a result of the application of the SGR.

*Imaging Payment Cuts Finalized.* CMS has frequently expressed concern about perceived overutilization and abuse in the area of advanced diagnostic imaging services (*e.g.*, CT, MRI and PET) and reimbursement rates for these services have been cut repeatedly in recent years. The 2010 MPFS Final Rule finalizes a new policy that would continue this trend. The methodology for calculating reimbursement for the technical component of advanced diagnostic imaging services has historically assumed an equipment utilization rate of 50%.<sup>9</sup> CMS previously

<sup>5</sup> See Medicare Physician Payment Reform Act of 2009 § 2, H.R. 3961 (111<sup>th</sup> Congress). Similar proposals were previously included in the House healthcare reform legislation approved November 7, 2009; however, the language was removed in order to reduce the overall cost of the reform bill and the proposal for a permanent fix to the Medicare physician payment system was introduced as an independent bill.

<sup>6</sup> *Id.* The cost of the bill (approx. \$210 billion over 10 years) is offset, in part, by increases in Medicare Part B premiums.

<sup>7</sup> See America's Healthy Future Act of 2009 § 3101, S. 1796 (111<sup>th</sup> Congress).

<sup>8</sup> See 74 Fed. Reg. at 33650.

<sup>9</sup> The equipment utilization rate is a major assumption used by CMS as the basis for calculating reimbursement rates for the technical component of advanced diagnostic imaging services. In earlier rulemakings, CMS noted that if the assumed utilization rate was too high, the result would be an insufficient allowance at the service level for the practice costs associated with the equipment; and if the assumed equipment usage percentage was set too low, the result would be an excessive allowance for the practice costs of equipment at the service level.

acknowledged that the assumption of 50% did not capture the actual usage rates for all equipment, but the agency did not believe that it had strong empirical evidence to justify any alternative approaches. In March 2009, the Medicare Payment Advisory Commission ("MedPAC") published new data about advanced diagnostic equipment utilization in its Report to Congress.<sup>10</sup> Based on this new data, CMS raises the equipment utilization rate in the 2010 MPFS Final Rule from the previous rate of 50% (approx. 25 hours per week) to a new rate of 90% (approx. 45 hours per week). The change will apply only to "expensive" MRI and CT equipment (*i.e.*, equipment priced at more than \$1 million) and will be phased in over a four-year period.<sup>11</sup> Medical imaging industry groups strongly object to the final rule, predicting that the increase in the equipment utilization rate could reduce reimbursement for the technical component of advanced diagnostic imaging services in CY 2010 by as much as 40%.<sup>12</sup>

### **Incentive Programs: Physician Quality Reporting Initiative and E-Prescribing Program**

The 2010 MPFS Final Rule broadens two existing incentive programs that allow medical professionals to earn higher Medicare reimbursements for reporting quality data and utilizing certain health information technology.

*Physician Quality Reporting Initiative.* The Physician Quality Reporting Initiative ("PQRI") is a voluntary program that allows physicians and other eligible professionals (collectively, "EPs") to earn incentive payments for reporting data on quality measures for covered professional services furnished to Medicare Part B beneficiaries during a specified reporting period.<sup>13</sup> EPs that satisfy the PQRI program requirements for CY 2010 are eligible to receive incentive payments equal to 2.0% of their estimated total allowed charges for all Medicare Part B covered professional services furnished during the applicable reporting period.

Under the current PQRI program, the determination of whether an EP satisfactorily reported quality data is made only at the individual professional level (based on the NPI) and incentive payments are made to practices to which payments are made for the individual EP's services (as designated by the entity's tax identification number). The 2010 MPFS Final Rule creates a new process for group practices to report quality measure data and qualify for the payment incentive based on a determination that the group practice, as a whole, satisfies the PQRI program reporting

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<sup>10</sup> See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2009), available at [http://www.medpac.gov/documents/Mar09\\_EntireReport.pdf](http://www.medpac.gov/documents/Mar09_EntireReport.pdf).

<sup>11</sup> *Id.* The proposed rule would have applied the change to equipment used in all advanced diagnostic imaging services priced at more than \$1 million (not just MRI and CT equipment). CMS has also clarified that the new equipment utilization rate assumption will not apply to expensive therapeutic equipment. See CMS-1413-FC at 86 (emphasis added). Although the scope of the changes implemented by the final rule is less than originally proposed, CMS will continue to review data related to the usage rates of equipment priced at less than \$1 million.

<sup>12</sup> When the change was proposed in July, industry groups complained that the MedPAC, recommendation serving as the impetus for CMS's proposal was based on limited and outdated survey data (accounting for services provided in just six urban areas).

<sup>13</sup> See CMS-1413-FC at 244-245. "Eligible professionals" include physicians (*i.e.*, M.D., D.O., D.P.M., O.D., D.D.S. (oral surgery), D.D.M., and D.C.), non-physician practitioners (*i.e.*, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists (and anesthesiologist assistants), certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals and audiologists), physical therapists, occupational therapists and qualified speech-language therapists. See CMS, "Physician Quality Reporting Initiative, Eligible Professionals," available at [http://www.cms.hhs.gov/pqri/10\\_eligibleprofessionals.asp](http://www.cms.hhs.gov/pqri/10_eligibleprofessionals.asp). See also CMS-1413-FC at 245.

requirements. Incentive payments to a group practice under the PQRI program are in lieu of the incentive payment that would otherwise be made to eligible EPs in the group practice. Individual EPs participating in a group practice reporting option can no longer separately earn a PQRI incentive payment as an individual. The final rule also adds new quality measures that EPs and group practices may report under the PQRI.

There are two mechanisms by which EPs may report quality data under the current PQRI program: (1) claims-based reporting (where data is extracted from claims information); and (2) registry-based reporting (which entails EPs submitting data to a qualified PQRI registry and requesting that the registry submit the data to CMS on behalf of the EP). For CY 2010, CMS will provide a new mechanism for participants to submit quality measure data from a qualified electronic health record ("EHR"). Previously, the EHR-based measure submission was voluntary and did not count toward eligibility for incentive payments. Beginning in 2010, these EPs and group practices who report data on three or more of the ten EHR-based PQRI measures will be eligible for the incentive payment.<sup>14</sup>

*E-Prescribing Incentive Program.* In an effort to promote the use of e-prescribing, CMS established a five-year program in 2009 that provides incentive payments to EPs who are determined to be "successful electronic prescribers" and penalizes those who are not successful electronic prescribers. Under the 2010 program, "successful electronic prescribers" are eligible to receive incentive payments equal to 2.0% of their total estimated Medicare Part B physician fee schedule allowed charges for all covered professional services furnished during the applicable reporting period.<sup>15</sup> The e-prescribing program incentives are separate from, and available in addition to, any incentive payments that may be earned through the PQRI incentive program.<sup>16</sup> Beginning in 2012, EPs who are not determined to be "successful electronic prescribers" will be assessed a penalty.<sup>17</sup>

The determination of whether an EP qualifies as a "successful electronic prescriber" under the current e-prescribing incentive program is made only at the individual professional level (based on the NPI) and incentive payments are made to the practice to which payments are made for the individual EP's services (as designated by the entity's tax identification number). The 2010 MPFS Final Rule creates a new process for group practices to qualify as "successful electronic prescribers" based on a determination that the group practice, as a whole, satisfies the program requirements. The final rule also simplifies the reporting requirements under the program, permits participants to submit data using a qualified EHR product and broadens eligibility for the e-prescribing incentive by adding professional services furnished in skilled nursing facilities, domiciliary care, or home care settings to the list of covered professional services under the e-prescribing incentive program. Following the distribution of incentive payments for services

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<sup>14</sup> *Id.* A list of qualified EHR products will be posted on the PQRI portion of the CMS website at <http://www.cms.hhs.gov/PQRI>.

<sup>15</sup> *Id.*

<sup>16</sup> See CMS-1413-FC at 501. However, if the EP or group practice earns an EHR incentive payment under the HITECH provisions of the American Recovery and Reinvestment Act of 2009, the EP or group practice would not be eligible for a separate incentive payment under the e-prescribing program. See 74 Fed. Reg. 33520, 33594 (July 13, 2009).

<sup>17</sup> See CMS, "Electronic Prescribing Incentive Fact Sheet" (October 2008), available at <http://www.cms.hhs.gov/ERxIncentive/Downloads/erxintroeprescribing.pdf>. EPs and group practices that are not successful e-prescribers by 2010 would see a downward adjustment in their fee schedule by 1.0% for the 2012 reporting year, a 1.5% reduction in 2013, and a 2.0% reduction in 2014. *Id.*

furnished in CY 2010, CMS will post the names of EPs and group practices that are determined to be "successful electronic prescribers" on its website.

### **Clarifications of Stark Commentary and Request for Comments**

*"Stand in the Shoes" Commentary.* Phase III of the Stark regulations, issued in 2007, as amended by the 2009 final inpatient prospective payment system ("IPPS") rule, added a provision under which all physician owners (other than titular owners) of a group practice are treated as "standing in the shoes" of their physician organizations for purposes of applying the rules that define direct and indirect compensation arrangements in 42 C.F.R. § 411.352.<sup>18</sup> Since the promulgation of the stand in the shoes rule, CMS has been grappling with several ambiguities and misinterpretations arising from the regulatory language. For example, the language apparently led many to believe that everyone within a physician organization (i.e., all members, employees, and independent contractor physicians) must be signatories to all of the various arrangements between the physician organization and each DHS entity. See CMS-1413-FC at 956-959. CMS rectified the misinterpretation in January 2008 by posting an FAQ on the CMS website.<sup>19</sup>

In addition, according to CMS, some members of the industry erroneously applied the stand in the shoes provision by analyzing only whether the compensation takes into account the referrals between the entity furnishing DHS and the physician who stands in the shoes of the physician organization, not the referrals of all members, employees and independent contractor physicians in the physician organization. In the 2010 MPFS Final Rule, CMS revises the Stark regulations to clarify that the relevant referrals and other business generated between the physician organization and the entity furnishing DHS are the referrals of all physicians in the physician organization, including all members, employees, and independent contractor physicians (and not simply the referrals made by each physician who stands in the shoes of the physician organization).<sup>20</sup>

*Request for Comments Regarding the Definition of "Entity" Under Stark.* In the 2009 IPPS final rule, CMS revised the definition of "entity" under Stark to include any person or entity that has "performed services that are billed as DHS" (in addition to any person who submits a claim for

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<sup>18</sup> For a more detailed description of the stand in the shoes provision, as well as other changes implemented in Phase III of the Stark regulations, please see our *Health Law Updates* entitled "Stark Phase III Regulations, First of Two-Part Series: 'What Meets the Eye,'" dated September 14, 2007 and "Stark Phase III Regulations, Second of Two-Part Series: 'More than Meets the Eye,'" dated October 12, 2007, each available at <http://www.bassberry.com>. Under the stand in the shoes provision, a physician owner who stands in the shoes of his or her physician organization would be considered to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization in whose shoes the referring physician stands.

<sup>19</sup> See CMS FAQ #8885, available at [https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_adp.php?p\\_faqid=8885&p\\_created=1201802755&p\\_sid=ceE\\_7VMj&p\\_accessibility=0&p\\_redirect=&p\\_lva=&p\\_sp=cF9zcmNoPTEmcF9zb3J0X2J5PSZwX2dyaWRzb3J0PSZwX3Jvd19jbnQ9MSwxJnBfcHJvZHM9MCZwX2NhdHM9JnBfcHY9JnBfY3Y9JnBfc2VhcmNoX3R5cGU9YW5zd2Vycy5zZWZwY2hfbmwmcF9wYWdlPTEmcF9zZWZwY2hfdGV4dD04ODgl&p\\_li=&p\\_topview=1](https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=8885&p_created=1201802755&p_sid=ceE_7VMj&p_accessibility=0&p_redirect=&p_lva=&p_sp=cF9zcmNoPTEmcF9zb3J0X2J5PSZwX2dyaWRzb3J0PSZwX3Jvd19jbnQ9MSwxJnBfcHJvZHM9MCZwX2NhdHM9JnBfcHY9JnBfY3Y9JnBfc2VhcmNoX3R5cGU9YW5zd2Vycy5zZWZwY2hfbmwmcF9wYWdlPTEmcF9zZWZwY2hfdGV4dD04ODgl&p_li=&p_topview=1). In this FAQ, CMS states that physicians standing in the shoes of their physician organization do not need to sign agreements between the physician organization and the DHS entity because CMS considers such a physician to have signed the agreement when the physician organization's authorized signatory signs the agreement.

<sup>20</sup> See CMS-1413-FC at 960-961.

DHS).<sup>21</sup> Members of the healthcare industry have expressed concern about the potential ambiguity of the meaning of "performs" under the revised definition. To date, CMS has declined to provide a specific definition of the phrase "performed services that are billed as DHS" but has indicated that the agency considers a service to have been "performed" by a physician or physician organization if the physician or physician organization does the medical work for the service and could bill for the service, but the physician or physician organization has contracted with the DHS entity and the DHS entity bills for the service instead.<sup>22</sup>

The agency went on to state that it would not consider an entity that (a) leases or sells space or equipment used for the performance of the service, or (b) furnishes supplies that are not separately billable but used in the performance of the medical service, or (c) provides management, billing services, or personnel to the entity performing the service, to perform DHS.<sup>23</sup> CMS has not, however, given definitive guidance on what combination of the foregoing components might cross the line into "performing" the services. In the final rule, CMS solicits comments to determine if further guidance is necessary and, if so, what clarification(s) may be beneficial to the industry in interpreting and applying the revised definition of entity.

### **Other Changes**

CMS also announced the implementation of the following changes in the 2010 MPFS Final Rule:

*Accreditation of Advanced Imaging Services.* Beginning January 1, 2012, suppliers of the technical component of advanced imaging services (e.g., CT, MRI and PET) must be accredited by CMS-approved accrediting organizations ("AOs"). The accreditation requirement will apply to mobile units, physicians' offices, and independent diagnostic testing facilities that create the images, but will not apply to the physician who interprets them.

*Initial Preventive Physical Exam ("IPPE").* In the final rule, CMS increased the payment for the IPPE (also known as "Welcome to Medicare") to compensate providers for additional services that must be provided as a part of the exam beginning January 1, 2010.

*Mental Health Parity.* CMS increased the Medicare share of payments for outpatient mental health services from 50% to 55%, beginning the gradual transition to bring payment parity for mental health and medical services furnished to Medicare beneficiaries required by the Medicare Improvements for Patients and Providers Act of 2008.

*New Medicare Benefits for Cardiac Rehabilitation Services, Pulmonary Rehabilitation Services and Chronic Kidney Disease Education.* CMS finalized new Medicare benefit categories for cardiac rehabilitation services, pulmonary rehabilitation services, and chronic kidney disease education services, beginning January 1, 2010. The final rule outlines what these programs would entail, how they would be reimbursed under the MPFS, and the criteria for covering these services. Coverage under the new benefits for cardiac rehabilitation services and pulmonary rehabilitation services will be based on the implementation of a physician-supervised program for individual patients that include physician-prescribed aerobic exercise, evaluation, training, education and outcomes assessments. Services under the new chronic kidney disease education benefit must include face-to-face educational services by a physician, physician assistant or nurse

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<sup>21</sup> See 73 Fed. Reg. 43754 (Aug. 27, 2009).

<sup>22</sup> See CMS-1413-FC at 964.

<sup>23</sup> *Id.* (citing 73 Fed. Reg. at 48726).

practitioner, or certain rural service providers, in which a patient is provide with comprehensive information regarding kidney disease, therapeutic and treatment options, test results, management of co-morbidities and assessment of outcomes.<sup>24</sup>

If you have any questions about any of the topics in this *Health Law Update*, please contact one of the attorneys in our Healthcare Practice Group listed below.

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<sup>24</sup> See CMS-1413-FC at 752-754.

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