

# Value ~ Added

A Publication of the Feeley & Driscoll, P.C. Health Care Services Group

## Advance Beneficiary Notices

We understand that many hospital providers have not yet fully operationalized the compliance requirement to furnish Medicare beneficiaries with an Advance Beneficiary Notice (ABN) in situations where one would be appropriate.

In light of recent communications from CMS and the OIG, we believe that the failure to implement an effective ABN process may represent a significant compliance vulnerability for Medicare providers.

An ABN is a written notice that you give to Medicare patients (including those who are dually-eligible for Medicare and Medicaid) before items or services are furnished when you believe that Medicare probably or certainly will not pay for the services. The purpose of an ABN is to inform your patients, before they receive services that otherwise might be paid for, that Medicare probably will not pay for them on that particular occasion (e.g. because of a service frequency limitation). This forewarning allows the beneficiary to make an informed consumer decision whether or not to receive services for which they might have to pay out-of-pocket (or through supplemental insurance).

Industry attention to ABNs as a compliance issue has been growing since this summer, when CMS released a lengthy and sometimes confusing Program Memorandum summarizing the requirements for implementing ABNs. (Transmittal AB-02-114, July 31, 2002).

In addition, an OIG Special Advisory Bulletin released in August 2002 on "Offering Gifts and Other Inducements to Beneficiaries" has also put some hospitals on notice regarding ABNs. The Special Advisory Bulletin does not specifically address ABNs, but it does explain the current law regarding inducements, which "bars the offering of remuneration to Medicare or Medicaid beneficiaries where the person offering the remuneration knows or should know that the remuneration is likely to influence the beneficiary to order or receive items or services from a particular provider." The 'should know' standard is met if a provider

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acts with deliberate ignorance or reckless disregard. No proof of specific intent is required.

How does the law against inducements relate to ABNs? When an ABN is properly furnished to a Medicare beneficiary, and Medicare subsequently denies payment for that service, a provider may then bill and collect from the beneficiary. If the provider fails to furnish a proper ABN in a situation where one is required, however, the provider may not seek reimbursement from the beneficiary (or their supplemental insurance). The result is that the beneficiary has obtained free services of value for which they would otherwise have to pay.

So if a hospital never furnishes ABNs to Medicare patients (for whatever reason — administrative burden, inadequate staffing, et cetera), could such routine failure then be considered sufficient to establish ‘deliberate ignorance’ or ‘reckless disregard’ to the law regarding inducements?

The OIG says “maybe.” The answer would depend on the facts and circumstances of the particular situation, of course. In some cases, the routine failure to obtain an ABN, with the result that beneficiaries obtain free services for which they would otherwise have to pay, would implicate the prohibition against inducements. The key question is whether the practitioner failing to furnish the ABN knows or should know that such practice is likely to influence the beneficiary’s choice of practitioner. The Special Advisory Bulletin notes that even if a provider does not directly advertise or promote the availability of a benefit to beneficiaries, there may be indirect marketing or promotional efforts or informal channels of information dissemination, such as ‘word of mouth’ promotion. In addition, the OIG considers the provision of free goods or services to existing customers who have an ongoing relationship with a provider likely to influence those customers’ future purchases.

We are encouraging all of our clients in the hospital industry to take a closer look at this issue. From a compliance perspective, the optimal solution is to implement a practical, sustainable structure of internal controls — including formal, documented policies and procedures — to increase the likelihood that ABNs will be furnished when appropriate. Easier said than done, however. Implementing a truly effective ABN process often requires a measurable amount of institutional commitment on the part of a hospital — including continuous staff education regarding Medicare coverage guidelines and local medical review policies. Issuing blanket ABNs to every Medicare beneficiary is not sufficient. Each ABN must explain the specific reasons why the hospital thinks Medicare is likely (or certain) to deny payment in that particular circumstance.

## Web Site of the Month

### *CMS Health Care Industry Market Updates*

The Centers for Medicare and Medicaid Services (CMS) recently released the sixth report in its ongoing series of Health Care Industry Market Updates. The latest update focuses on the financial and market performance of pharmaceutical manufacturers — including both branded and generic pharmaceutical companies, as well as biotechnology firms. Over the past five years, according to CMS, all three of these industry sectors have outperformed the Standard & Poor’s “S&P 500,” which is essentially an index of the 500 largest companies in the United States.

A summary of the report on drug manufacturers has been posted to our website at:

[www.fdcpa.com/cms.pharmaceuticals.2003.htm](http://www.fdcpa.com/cms.pharmaceuticals.2003.htm)

To prepare these updates, CMS’ Office of Research, Development & Information (ORDI) gathers research reports from the major Wall Street investment firms, summarizes their analyses, and condenses them.

Previous market updates from CMS have covered the following industry sectors:

- Medical device and supply manufacturers (released October 2002)
- Home health care providers (July 2002)
- Acute care hospitals (April 2002)
- Nursing facilities (February 2002)
- Publicly-traded managed care organizations (November 2001)

In coming months, CMS intends to review specialty hospitals, hospice providers, and virtually every other major healthcare provider and supplier sector.

As they are released, the reports will be posted to the CMS website at:

[www.cms.gov/reports/hcimu/](http://www.cms.gov/reports/hcimu/)

## CMS Program Memorandums - January 2003

### **January Medicare Outpatient Code Editor (OCE) Specifications Version 18.1 For Bills From Hospitals That Are Not Paid Under the Outpatient Prospective Payment System (OPPS)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-7-03, Transmittal No. A-03-001, Change Request 2522.

### **Noncoverage of Multiple Electroconvulsive Therapy (MECT)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid (CMS)

*Action:* 1-10-03, Transmittal No. AB-03-003, Change Request 2499.

### **CWF Change for Billing for Glucose Test Strips and Supplies – Follow-up to CR 2156**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-24-03, Transmittal No. B-03-004, Change Request 2363.

### **Installation of Version 28.0 Add-On of the Provider Statistical and Reimbursement (PS&R) Report**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-10-03, Transmittal No. A-03-002, Change Request 2529.

### **Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-10-03, Transmittal No. AB-03-002, Change Request 2515.

### **FY 2003 Systems Security Activities and Due Dates**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-24-03, Transmittal No. AB-03-005, Change Request 2518.

### **April Quarterly Update for 2003 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-24-03, Transmittal No. AB-03-006, Change Request 2535.

### **DMERCs – VIPS Medicare System (VMS) Implementation to Process ICD-9 CM Codes Using Date of Service and Not Date of Receipt**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-24-03, Transmittal No. B-03-002, Change Request 2558.

### **Health Insurance Portability and Accountability Act (HIPAA) Transaction 835v4010 Companion Document Update for Intermediaries**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS)

*Action:* 1-24-03, Transmittal No. A-03-005, Change Request 2498.

### **Second Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS)

*Action:* 1-24-03, Transmittal No. AB-03-007, Change Request 2470.

This PM is the second set of instructions to provide additional guidance on issues related to the implementation of the ambulance fee schedule.

During the implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen which require clarification. This PM provides additional guidance on these issues, and supplements previously issued instructions regarding the implementation of the ambulance fee schedule.



## Expanding Your Reach Without Endangering Your Exempt Status

Joint ventures between nonprofit groups and for-profit businesses often further the goals of both, and “partnering” continues to flourish in the nonprofit community. Not surprisingly, the IRS is looking at more joint ventures than ever. Fortunately, it has widened the range of partnership structures it finds acceptable.

While the IRS hasn’t provided comprehensive guidance, a close review of rulings and court decisions can help charities achieve their goals without endangering their tax-exempt status.

### “STRICT SCRUTINTY” TEST

Basically, a nonprofit partner will retain its tax-exempt status *only if* the joint venture furthers the organization’s charitable purpose and is organized in a way that ensures the nonprofit will act *exclusively* to further that purpose, without private benefit to the for-profit partner.

Charities with for-profit partners should avoid impermissible private benefits. One safeguard is to put your charity in control by establishing it as the sole general partner or majority co-general partner. Alternatively, establish your charity’s veto power over decisions that might hamper its ability to further its exempt purpose.

Limit your liability – don’t commit the charity’s assets to protect the interests of the for-profit investors. Meticulously structure guarantees. If your organization takes on additional risk, it must be adequately compensated, receiving at least a proportionate benefit in every instance. Investor benefits must be *incidental* to achieving your charitable purpose.

### SUCCESSFUL JOINT VENTURES

Many partnerships meet with IRS approval every year. Here are some examples of common joint ventures addressed by the IRS and the courts.

**Partnership:** A magnetic resonance imaging (MRI) facility is operated by a nonprofit hospital and a group of doctors.

**Benefits:** Indigent patients receive priority treatment, the community receives needed facilities, and the doctors receive a reasonable return on their investment.

**Partnership:** Low-income housing and related social services are provided by partnerships between charities and Fortune 500 companies.

**Benefits:** Individuals earning below the region’s median wage receive safe and affordable housing, and the public company earns a dependable return on its investment, including valuable low-income housing tax credits.

**Partnership:** Home office buildings are acquired by nonprofits joining with local investors.

**Benefits:** The charity rents office space at below market rates and the local investors receive a return on their investment as well as a portion of the appreciation when the building is sold.

### RED FLAGS

There are certain circumstances that are likely to attract the IRS’s attention. Avoid the following when structuring your joint venture:

- Loans or transactions at less than fair market value that favor the for-profit partner
- Issuing contracts without competitive bidding or comparison pricing
- Nonprofit and for-profit co-general partners that are closely related
- Both nonprofit and for-profit entities under the management or control of insiders
- Allocations of profits and losses that disproportionately favor the for-profit partner

### BEFORE TYING THE KNOT

Don’t finalize any joint venture plans without having them reviewed by a group that includes a CPA and a lawyer with extensive nonprofit and joint venture experience. Make sure the partnership documents *specifically* allow your charity to set further its exempt purpose, even when this violates its fiduciary duty to the other partners. Maintain primary control of the joint venture by having at least 51% voting control of the board.

And, last but not least, document all decisions. If you don’t, the IRS may think you are hiding something.



## 8 Simple Rules to Billing for Observation Services

Observation services are services furnished by a physician to evaluate and determine if a patient's symptoms or condition warrants admission as an inpatient.

The observation codes have specific coding guidelines that at times can be very confusing. It is important to understand the billing and coding requirements for observation services in order to obtain correct payment. Below are 8 easy to follow guidelines to help illustrate the correct procedure for billing observation services.

### 1. **Bill the initial observation care codes 99218-99220 only if the physician is the one who admits the patient to hospital observation.**

The observation codes are to be used by physicians who are authorized to admit a patient to observation status and by physicians who have conventional admitting privileges. Only the physician who admitted the patient to hospital observation and is responsible for the patient during his/her stay in observation may bill the observation codes.

In order to bill for observation codes, there must be a medical observation record separate from other medical records. This medical observation record must contain the date and time of physician orders regarding the care the patient is to receive while in observation, and include any nursing notes and progress notes prepared by the physician during the course of observation.

Evaluation and management services on the same date provided in sites that are related to the initiating of observation status should not be reported separately. All services provided by the supervising physician in conjunction with initiating observation status are considered part of the initial observation care when performed on the same date.

### 2. **Use other office, outpatient or outpatient consultation codes as appropriate for physicians other than the admitting physician who see the patient while in observation.**

If during the course of observation services, another physician sees the patient, that physician must bill a regular evaluation and management code.

### 3. **Report observation admission and discharge codes 99234-99236 for admission and discharge of a patient from observation on the same calendar date**

The patient must be in observation for at least 8 hours on the same date. Documentation must show:

- A stay involving 8 hours, but less than 24 hours.
- The billing physician was present and personally performed services; and
- The admission and discharge notes were written by the billing physician

### 4. **Bill the initial observation care codes 99218-99220 when a patient is admitted to observation for less than 8 hours on the same date**

### 5. **Use code 99217 for observation care discharge**

This code should be billed when with discharge from observation status occurs on a different date from the date of admission.

### 6. **Bill an initial hospital visit code 99221-99223 if the patient is admitted as an inpatient on a date after the patient was admitted for observation**

### 7. **Report only initial hospital care codes 99221-99223 if physician admits a patient to observation and then to inpatient status on the same day**

### 8. **Use an appropriate office / outpatient code for each day between admission and discharge**

In the unusual situation where a patient remains in observation status for more than two days, do not use the subsequent hospital care codes for those days.

CMS has confirmed that, "when a patient is admitted for observation care and then discharged on a different calendar date, the physician should report initial observation care codes 99218 through 99220 for the date of admission, and CPT observation care discharge code 99217 on the date of discharge. The admitting physician providing observation care on a day to the patient cannot bill more than once per day. It is an all-inclusive payment for that physician with that patient for the day – just like most E&M services. Observation care service is not like critical care, which is time based.

## Federal Register Summary - January 2003

### **CENTERS FOR MEDICARE AND MEDICAID SERVICES**

#### **Fire Safety Requirements for Certain Health Care Facilities**

1-10-03 (Vol. 68, No. 7, pages 1374-1388)

*Agency:* Centers for Medicare and Medicaid Services (CMS), HHS

*Action:* Final Rule.

This final rule amends the fire safety standards for hospitals, long-term care facilities, intermediate care facilities for the mentally retarded, ambulatory surgery centers. Hospices that provide inpatient services, religious nonmedical health care institutions, critical access hospitals, and Programs of All-Inclusive Care for the Elderly facilities. Further, this final rule adopts the 2000 edition of the Life Safety Code and eliminates references in our regulations to all earlier editions.

### **DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) AND CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)**

#### **Program Exclusions: December 2002**

1-21-03 (Vol. 68, No. 13, pages 2784-2787)

*Agency:* Office of Inspector General, HHS

*Action:* Notice of program exclusions.

#### **2003 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid (CMS)

*Action:* 1-03-03, Transmittal No. A-02-129, Change Request 2503.

#### **Revision to 42CFR 405.371 Suspension, Offset and Recoupment of Medicare Payments to Providers and Suppliers of Services**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid (CMS)

*Action:* 1-3-03, Transmittal No. A-02-128, Change Request 2508.

#### **Emergency Update to the 2003 Medicare Physician Fee Schedule Database**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-17-03, Transmittal No. B-03-001, Change Request 2530.

#### **Calculating Provider-Specific Medicare Outpatient Cost-to-Charge Ratios (CCRs) and Instructions on Cost Report Treatment of Hospital Outpatient Services Paid on a Reasonable Cost Basis**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 1-17-03, Transmittal No. A-03-004, Change Request 2197.

#### **Provider Notification of Denials Based on Local Medical Review Policy (LMRP)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid (CMS)

*Action:* 1-03-03, Transmittal No. AB-02-184, Change Request 2305.

## Feeley & Driscoll, P.C.

### Reimbursement Roundtable Series

As you know, Feeley & Driscoll, P.C. is hosting a series of complimentary roundtables designed to help you and your staff stay abreast of breaking issues impacting your institution's financial position.

Each roundtable will include discussions lead by a combination of experts from Feeley & Driscoll's Healthcare Services Group and outside agencies, payors and regulators.

We encourage you to send a member (or members) of your team to participate in these valuable, timely and informative sessions. All meetings will be held at F&D's Training Center, 200 Portland Street, Boston, MA 02114. Please call Scott Cavallo at (617)742-7788 x369 or email ScottC@fdcpa.com to reserve your space now. We look forward to seeing you.

Visit our web site at [www.fdcpa.com/healthcare.seminars.asp](http://www.fdcpa.com/healthcare.seminars.asp) for the 2003 schedule of Reimbursement Roundtables!

## Compliance Corner

An update on recent activity by the Department of Health and Human Services Office of Inspector General (HHS-OIG)

The OIG is responsible for conducting audits, evaluations, and both criminal and civil investigations for all HHS agencies. These functions are performed by the OIG's Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), and Office of Investigations (OI), respectively.

**Semi Annual Report – “OIG Saves Taxpayers Record \$21 Billion”** The OIG released its semiannual activity report of enforcement activities covering April 2002 – September 2002. The Inspector General Act of 1978 requires that the OIG report on activities semiannually to the head of the HHS and to the Congress. The government's crackdown on healthcare program fraud and abuse shows no sign of stopping. The OIG reports savings to taxpayers of a record \$21 billion in FY 2002. That is \$3 billion more than in FY 2001. The OIG performed 2,372 audits and filed 1,654 criminal and civil cases in FY 2002. The OIG states two major reasons for its success – streamlining and cost reduction measures. According to the OIG, however, the bulk of program savings have come from providers' own efforts to comply with government regulations.

To read the full report, go to:  
<http://www.oig.hhs.gov/publications/docs/semiannual/2002/semiannualfall02.pdf>

**Oversight of Medicare PPS – Exempt Hospital Services** – The OIG released a final inspection report on the review of Prospective Payment System (PPS) – exempt inpatient services for reasonableness and medical necessity. In addition to acute care hospitals, Part A covers inpatient care in psychiatric, rehabilitation, critical access, and long-term care hospitals. Each of these specialty hospitals is exempt from the PPS. At the time of the inspection, the OIG found that routine statistical analysis and medical review of PPS – exempt inpatient services for medical necessity and reasonableness were not being conducted. The OIG took information regarding improper payments attributed to PPS – exempt facilities from the OIG Office of Audit Service report, “Improper Fiscal Year 2000 Medicare Fee-for-Service Payments”. The OIG discovered that Medicare paid approximately \$8.7 billion to PPS – exempt hospitals in 2000. They attributed \$800 million of improper payments to issues of medical necessity in PPS – exempt facilities.

To read the full report, go to:  
<http://oig.hhs.gov/oei/reports/oei-12-02-00170.pdf>

Review of Anesthesia, Pharmacy and Supply Services Incident to Other Outpatient Diagnostic Services Processed by Associated Hospital Services - Many hospitals serviced by Associated Hospital Services (AHS) did not establish adequate internal controls to ensure that claims for anesthesia, pharmacy, and medical supply services used incident to other outpatient diagnostic services were coded in accordance with Medicare requirements. This was particularly true of providers of cardiac catheterization services. Hospitals that rendered cardiac catheterizations, incorrectly coded pharmacy, anesthesia, and medical supplies using general revenue codes instead of specific revenue codes required when billing for services incident to other outpatient diagnostic services. The hospitals overcharged an estimated \$518,000 on claims submitted to AHS. As recommended by the OIG, AHS has asked their 8 serviced hospitals that provide cardiac catheterization services to perform related self-audits. This issue has since been corrected with the implementation of OPPS.

To read the full report, go to:  
<http://158.70.174.5/oiginternet/oas/reports/region1/10100542.pdf>

Medicare Bad Debts - The OIG published ten separate reports on this subject in 2002 to determine whether Medicare bad debts claimed by each facility on their cost report, met Medicare reimbursement requirements. The OIG found that each facility did not comply with Medicare criteria. The amounts overclaimed ranged from \$6,000 - \$558,807. The OIG recommended that each facility strengthen their internal procedures for bad debt reporting practices and to adjust cost reports for the overstated amounts.

To read the latest report on bad debts, go to:  
<http://oig.hhs.gov/oas/reports/region6/60200002.pdf>

### Contact Feeley & Driscoll

Please visit [www.fdcpa.com/healthcare.htm](http://www.fdcpa.com/healthcare.htm) to receive the latest health care news and the dates and agendas of our upcoming Reimbursement Roundtables for Hospitals and Long Term Care Providers

If you have any questions or would like to discuss further any of the issues discussed in Value Added with one of our health care specialists, please contact us at (617) 742-7788 or

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### Coding Corner - Critical Care

Physicians have misused critical care services for many years. Current Procedural Terminology (CPT) defines critical care as the direct delivery by a physician(s) of medical care for a critically ill or critically injured patients. Factors that must be present in order to bill the critical care codes (99291-99292) are:

- Threat to vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition
- Constant attention required of the provider for the time(s) coded and billed.

Critical care mandates high complexity medical decision making in order to assess, manipulate, or treat the condition. Critical care service(s) comprises several comprehensive services that make up the critical care charge. They include:

- Cardiac output measurement interpretation (93561-93562)
- Chest x-rays (71010, 71015, 71020)
- Pulse oximetry (94760 – 94762)
- Information data stored in computers (99090)
- Temporary transcutaneous pacing (92953)
- Gastric intubation (43752, 91105)
- Ventilation management (94656 – 94662)

- Vascular access procedures (36000, 36410, 36415, 36540, 36600)

Report separately any other service(s) provided during critical care that do not appear on the list above.

Because the critical care codes are time based, it is possible for more than one code to be billed by the physician a day. The documentation must reflect the total time spent by the physician providing constant attention to the unstable, critically ill, and / or injured patient. The critical care time is calculated by the total amount of time spent with the patient on a specific date. It may also include critical care time that is not continuous for the same date. Per CPT, time spent engaged in work directly related to the individual patient's care elsewhere on the floor or unit may also be reported in the critical care code. For example, time spent on the unit reviewing test studies or discussing the patient with other staff may also be reported.

Code 99291 is used to report the first 30 to 74 minutes of care, and should only be billed once per calendar date. Code 99292 is used to report each additional half hour of care. Please note that 99292 is an add-on code and cannot be used without first billing the 99291. For pediatric or neonatal critical care, refer to CPT codes 99293 – 99296.

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