Introduction

Good afternoon everyone and welcome to the CGS Administrators DME MAC Jurisdiction B Reopenings and Redeterminations Ask-the-Contractor Teleconference (ACT). This call is being hosted by the Durable Medical Equipment (DME) Provider Outreach & Education Team for Jurisdiction B. That includes myself Terri Shoup, Stacie McMichel, and Ashley DeCoteau. Also on the ACT call this afternoon, we do have other Jurisdiction B subject matters experts from various departments.

We would like for you to keep in mind that for this ACT call, we ask that your questions are related to the aspects of the Reopenings and Redeterminations process. We do have general ACT calls in which you can ask questions regarding any topic but this call is specifically about Reopenings and Redeterminations.

Please keep in mind that for ACT calls, your questions must be asked verbally and that is be done by raising your hand. We will not answer questions that are submitted through the question feature of your Go-To-Webinar dashboard. The reason for that is ACT calls are recorded, transcribed and uploaded to our website. We have disabled the chat feature in Go-To-Webinar. When we get to the question portion of today’s call, I will go through the directions on how to raise your hand.

Once you are connected to the audio portion of our webinar today, be sure that you enter the pin number that displays on your screen into your telephone keypad. In order to unmute your line so you can ask a question during the Q&A portion, you will need to have entered your pin number.

Before we begin taking your questions, I did want to go through a few recent updates and reminders with you.

MNL Matters SE17010

Let’s start by reviewing MNL Matters SE17010. This MLN is titled, Improvements to the Adjudication Process, and was published in our CGS newsletter on May 2, 2017. This MLN informs the DME MACs of their ability to adjudicate serial claims when one denied claim in the series is overturned in Appeals and others have been denied for the same or similar reason. CGS is currently reviewing claims that are in question and we will adjust them when applicable.

MLN Matters MM9968

The next item I want to review is MLN Matters MM9968. This is titled, Extension of the Transition to the Fully Adjusted DMEPOS Payment Rates under Section 16007 of the 21st Century Cures Act, and was published in our CGS newsletter on May 9, 2017. This MLN provides guidelines for DME MACs to process non-competitive bid claims affected by the 21st Century Cures Act for dates of service July 1, 2016 through December 31, 2016.

In mid-May, per authorization from the Centers for Medicare & Medicaid Services (CMS), CGS conducted beta testing and sent a batch of claims through the system for adjustments. We are aware that a small volume of the claim adjustments resulted in an overpayment that could have previously been refunded. We are currently working with the shared system maintainer to correct this problem. Once all the issues are resolved, we will begin the full mass adjustment process in accordance with CMS instructions.

Keep in mind, the implementation of MM9968 is July 3 and we are expecting adjustments to begin at that time, if not sooner. We expect that most of the adjustments will result in a higher payment. The mass adjustments will continue until we are completed and we expect that to take approximately 24 weeks. A certain volume of claims will be released and adjusted each day. We expect the majority of the claim adjustments will be processed to completion without any manual adjudication.

Suppliers should review their remittance advices to watch for these adjusted claims. CMS has authorized DME Medicare Administrative Contractors (MACs) to add a remittance code of N689. This code will be added to identify adjustments on your remittance notice. The N689 message will state, “Alert! This reversal is due to a retroactive rate change.” It will be in the 2100.MOA segment of the electronic remittance advice and in the claim header of the MIA/MOA section on the printed remittance statement, which is also known as the standard paper remittance.

Please be aware that Cures Act adjusted claims will be processed against all online and common working file edits, such as inpatient stays in a skilled nursing facility, Medicare Advantage plan enrollment and home health episodes. Claims could deny based on these edits. You will receive an overpayment demand letter for these claims. It is also important to note that if there is a crossover agreement in place for adjusted claims, CGS will forward these claims to the appropriate health insurance carrier.

There is no need for suppliers to call the Provider Contact Center to see if your claims have been adjusted or to find out when your claims will be adjusted. We expect the mass adjustment process to take approximately 24 weeks to complete. We will notify all suppliers once the mass adjustment process is complete via ListServ announcements as well as posting to our social media accounts via Facebook and Twitter.

Once the mass adjustment process is complete, suppliers should submit a request to reopen their claim if it should...
have been processed with a KE Modifier. CGS recommends that requests to append the modifier be faxed to Written Reopenings. The fax number for Jurisdiction B is 615-660-5978 and for Jurisdiction C it is 615-782-4649. You will want to use the Reopenings Request template that is located on our website under Forms. You may submit a spreadsheet if you have multiple claims but you need to make sure you include the following information:

- Provider Transaction Account Number (PTAN)
- Health Insurance Claim Number (HICN)
- Name of the Beneficiary
- Date of Service
- Claim Control Number
- Healthcare Common Procedure Coding System (HCPCS) code
- Must clearly state that you want the KE Modifier added

Please keep in mind if you submit a spreadsheet, you should include no more than 250 claims per Reopening request.

To keep you updated on the adjustment process, we will be hosting webinars that are focused on MLN Matters MM9968. We currently have four live-line webinars that are scheduled for July and August that are designed to answer questions specifically regarding these adjustments. The webinars are scheduled for July 7, July 21, August 4 and August 18. Each webinar will start at 2:30 p.m. ET. You can register for any of these webinars by going to the Jurisdiction B or C Education Page of the CGS website and click on webinars.

### Telephone Reopenings

As a reminder to our supplier community, you may utilize our Telephone Reopenings process for all simple claim adjustments. This is much easier and faster than submitting a written Reopenings request. A few examples of items you can correct by calling Telephone Reopenings include:

- Diagnosis code changes
- Changing your dispensing fee from G0333 to Q0513
- Correcting a date of service

Keep in mind that you cannot utilize telephone reopenings to correct a date of service that is due to an overpayment. The Telephone Reopenings phone number for Jurisdiction B is 1.844.240.7490 and for Jurisdiction C it is 1.866.813.7878.

### ForeSee Satisfaction Website Survey

The last item I want to mention before I open up the phone lines for questions is the CMS ForeSee Satisfaction Website Survey. This survey pops up when you navigate through the CGS website or the myCGS Web portal. We ask that you take a few moments to take this survey whenever it is presented to you. Your input is vital and allows us to make changes to our website that will affect all suppliers. Virtually all the changes we’ve implemented to [http://www.cgsmedicare.com](http://www.cgsmedicare.com) have come from supplier input. Please use the survey to tell us what you like about the website, what you would like to see changed, and what you would like to see regarding future enhancements. It will only take a few moments of your time and we do value your opinion.

### Conclusion

As I prepare to take your questions, I do want to remind you that we will only take questions via the phone. This call is being recorded for transcription purposes so we will not take any questions through the Go-To-Webinar chat feature. To raise your hand, click on the icon with the hand. Then we will un-mute your individual line so that you may ask your question. Also remember that no claim specific information or Medicare private health care information should be verbalized. We will pause for just a moment so that you can prepare to ask your questions.

### Question and Answer Section

**Brittany:** I have a question about Reopenings. We have an initial date of service that was denied in an audit and we appealed it. During the audit process, we didn’t stop our claims from billing so the second, third and fourth month billed out. The third and fourth month denied due to the same reason as the audit. We received a favorable decision from Redetermination. What is the best way to get our third and fourth month claims re-processed? Do we file a written reopening, telephone reopening or redetermination?

**Terri:** To clarify, you had a series of claims that were all related and when submitted they denied. One claim was overturned in appeals and was paid but the remaining claims are still denied?

**Brittany:** Yes, they were denied because our billing system continued to release the claims prior to the appeal having completed.

**Terri:** These claims will fall under our serial claims adjustments. When one claim is overturned and the other claim denials are for the same or a similar reason, we should be able to overturn all the denials. CGS is currently working serial claim adjustments. If the issue has to do with incorrect dates of service, that can be corrected via Telephone Reopenings. If it is not related to an overpayment but is a simple correction of a date of service, you can call Telephone Reopenings and they can adjust any of claims that are related that have that same issue.

**Brittany:** Awesome! Thank you.

**Terri:** You’re welcome.

**Diane:** My question for you is what are the dates of the serial claims that are going to be revisited? We would like to run a report just to do a check and balance.

**Terri:** I believe we are looking at claims for the past three years. Stacie, would you verify that we are looking at serial claims for the last three years?

**Stacie:** That was my understanding that we could go back for three years.

**Diane:** So, you are going back to 2014?
**Ask the Contractor Teleconferences (ACT)**

**Michael:** It is January 2014. If we have issued a favorable Redetermination decision, your claims should be adjusted quickly once that favorable decision is made. They are adjusted concurrently with that decision.

**Diane:** Will you go in date order, as far as the reprocessing process?

**Jennifer:** I actually have two questions that came up this morning. The first one is correcting a detailed written order (DSO) after claims admission, after an appeal. Can we correct the DSO and then submit an appeal again to get it paid or would we have to write off our old accounts receivable (AR) and just start billing from that corrected date forward?

**Stacie:** I don’t believe you can correct a DSO after claims submission. That is one of the requirements for billing is that you must have the DSO prior to submitting your claim to Medicare. What type of error is on the order?

**Jennifer:** I didn’t write down the example, I just wrote down the question but it was for oxygen. It wasn’t on the certificate of necessity (CMN) but it was on the DSO.

**Stacie:** That is a different situation. If you have a separate written order and your CMN is incomplete, the CMN can be corrected if you are just using it as the CMN and not as a DSO. If that is the case, you can correct the CMN. Depending upon where you are, you would have to go through appeals with that. For the DSO, there are no provisions that will allow you to correct that after claims submission.

**Jennifer:** OK, thank you. The second question was regarding an email we received from a ListServ that said digitized signatures are now being accepted through the electronic submission of medical documentation (ESDM) portal. Is CGS accepting digitized signatures on the Redetermination form?

**Michael:** Yes, we are accepting them on Redeterminations.

**Jennifer:** Do they have to be dated and signed or can I just say signature was digitized?

**Michael:** It can just say signature was digitized.

**Jennifer:** OK, thank you.

**Stacie:** I have a couple of examples right here. Thank you.

**Kim:** One thing that would be helpful for us to trace your faxes is to be sure that in the header or footer of that transmission that your fax number is part of that. It is harder for us to trace if that fax number is not part of the header or footer.

**Teresa:** I believe it is on there.

**Terri:** I have your contact information and I will follow up with you after the call.

**Teresa:** That would be wonderful. Thank you.

**Michelle:** I have a question on addendums. For instance, for a hospital bed we are getting many denials for this repositioning situation. We send in the documentation and they state that it doesn’t go through the repositioning enough. So, we get an addendum from the doctor showing more information as far as why they require the repositioning for medical purposes. We submit that through and end up getting the same denial. I am just wondering what is the best way to handle those situations? Is an addendum ok to do?

**Terri:** So, you are sending it through Redetermination and it is coming back with the same denial?

**Michelle:** Correct. We start with the additional document request (ADR) and we get a not medically necessary denial for repositioning. We get further documentation from the doctor as an addendum to their face-to-face stating there is more detail as to what is needed. We send that information in on a Redetermination and then we are getting the same denial stating that it doesn’t qualify for the repositioning. When we get the addendums they are very specific so I’m not quite sure what information they are looking for. Who I can ask about that? If I call the customer service line, they are repeating exactly what it says on there.

**Terri:** I would need to look at your specific situation. Does the Redetermination letter give you a specific reason for getting the denial?

**Michelle:** It says the repositioning is not detailed enough, which doesn’t help me. But an addendum is the proper way to do this, correct?

**Terri:** Yes, there should not be an issue with completing an addendum. Michael, is there anyone in the room from an operational area that could help further?

**Michael:** Addendums are acceptable. If an addendum brings out additional information that was not in the original medical record though and it was added after the claim denial, that will not be shed in a good light in my opinion.

**Michelle:** In these situations, the doctor has this information in there. It is just not as detailed as it should be. They are updating their information in a more detailed way.

**Ashley:** An addendum should clarify information that is already in the medical record. It shouldn’t present any new information. This might be something we would have to research further. I will reach out to you after the call and get examples, Michelle.

**Michelle:** I have a couple of examples right here. Thank you.
Lori: We have two questions. Kind of along the same line as the other lady’s questions about when we send in a Redetermination and we get a letter saying it is favorable or it is reversed. Then, we get another explanation of benefits (EOB) saying it is denied for the same reason. The EOB has no appeal rights on it and when we call, they say it is appealable. We are kind of confused as to why it was saying it was favorable and get the EOB with same denial on it.

Terri: So, after you send it to Redetermination you receive a favorable decision that says we are going to re-process the claim but when we do, it is denied for the exact same reason and not for something different?

Lori: Correct.

Terri: This is something we would have to research further. I will get in touch with you to let you know where to send your examples.

Lori: OK. Can you tell us the difference between a favorable response versus one that says it has been reversed on the myCGS website?

Kim: They are basically the same thing. It is just a difference in terminology.

Lori: Thanks.

Luciano: I had a question about the digitized signatures. Did you say I could just insert an image of my signature on the Redetermination form?

Michael: Most everything that comes through esMD is a digital signature because of the way it is transmitted.

Luciano: If I wanted to fax it just to save paper, would I be able to put in an image of my signature on the Redetermination form?

Michael: We are looking for a signature.

Luciano: OK. I did want to be included in the information on Addendums and receiving the same denial after it goes to Redetermination as well as the issue of ADR responses not being received. I deal with those issues all the time. About 47% of my claim denials after ADR, are due to CGS saying they did not receive the fax, although we have confirmations. I just wanted to be included in that information/discussion afterwards.

Terri: Let me provide my email address and for anyone that has examples for the issues we have discussed on this call, you can send those directly to me. When you send your examples, ensure that you do not include protected health information (PHI). All you need to send is the claim number or claim control number (CCN) and exactly what the issues are and I will research further. My email address is Theresa.Shoup@cgadmin.com.

Luciano: That was all. Appreciate it.

Sheila: Is there ever going to be a time when we can start uploading Redetermination and audit responses?

Terri: Are you referring to uploading to the myCGS Web portal?

Sheila: Yes. We can currently do it for Noridian.

Terri: Yes, I do know this is an enhancement we are working on for the myCGS Web portal. We are anticipating we will roll out this enhancement by the end of this year.

Sheila: That would be a big help.

Christina: I have a clarification question on the digitized signature. The previous gentleman said he was having to sign the form, copy it, scan it and send it in. We received an update recently that we could do it electronically, digitized or digital and that is fine. Ours won’t stamp but we can add a signature on it digitally. Is that correct?

Michael: The requirement on the Redetermination form is that there has to be a signature.

Christina: A signature, period? Not how it is put on there?

Michael: Correct.

Evelyn: What options are available to providers when there is a unique situation with a beneficiary where she would need lifetime medical necessity for two-way catheters? Our claims keep getting denied, month after month, and we appeal, month after month, for a medical necessity that is proven. The appeals are paid yet we are still going through this cycle with this beneficiary. What are my options? Is there something Provider Relations can do with this beneficiary's account so you can somehow flag the account so that we don’t have to keep submitting appeals when last month it was already established that she needed the two-day catheter determined by her diagnosis code?

Stacie: I don’t believe we would flag the beneficiary to continue to pay for her services on a month by month basis. Correct me if I am wrong, Michael. Are you billing an excessive number to cause it to be denied? Is it within the normal parameters?

Evelyn: No, it is within the normal parameters. It is just that she is a female and she requires two-way catheters. It has been denied for other reasons as well. When we receive a favorable decision on the appeal, then the next month it is denied for some other reason. It is just a continual headache. I’m sure you have enough paperwork from us on this customer, I don’t know what, but you have a lot! She has been on service with us for five years. Maybe I am exaggerating when I say monthly but I’m sure it is every other month with this customer. Her diagnosis isn’t changing. She has a unique medical condition and I don’t understand why on your end you cannot identify this type of beneficiary and do something with the account, especially since this is going to be a lifetime issue for this person. She is absolutely going to require catheters for her lifetime…designated by her doctor. It is all in the medical notes yet we are playing this game every other month.

Stacie: Without looking at that patient’s history, it is hard to give an answer. And if the claim is not denied the same way every month, it is hard to say what is going on.
Evelyn: Typically, it does deny for the same reason. I have also been talking to a supervisor and they are in the process of looking at the account. This has been going on for months and I have no answers. Once again, I find it hard to believe in this day and age when a beneficiary has a unique situation that Medicare can’t take a look at the whole picture versus a monthly amount of catheters and somehow flag it in the system so that we are not inundated with the necessity of filing appeals until the end of time.

Stacie: Is there someone from MR that can elaborate on this?

Michael: Would you be kind enough to send in an appeal number so we can look at it and possibly get Medical Review involved? Maybe a long-term flag exception might be made.

Evelyn: That would be great. I would appreciate any help I can get because this has been going on for months. To whom should I send the appeal number?

Terri: You can send it to me and I will ensure it gets to the appropriate department.

Evelyn: Thanks for your time.

Michelle: We also have a patient that needs special catheters. Every month we submit a claim and get a denial and the documentation must be sent in again. I do this monthly. When I call and tell them that I send these in every month, they say that because it is not capped rental, it is going to hit an audit or an edit and deny no matter what we do. That is what I was told by customer service and there is no way around this. It is just a waste of time and it seems it is taking longer for us to get paid because it can take up to 60 days for Redeterminations.

Terri: Was the person you spoke with in Customer Care?

Michelle: Yes, the main line. I have called a couple of different times and have talked with four different people. This also happens with advanced determinations of Medicare coverage (ADMCs) and anything that goes through with a GA modifier, I get a denial for. Then, I must submit all the medical documentation along with the advance beneficiary notice (ABN). The ABN modifiers just started at the beginning of this year, I believe. I’m not understanding why we must keep submitting this stuff repeatedly and why the ABNs are being denied now. Is that just so you can get the ABN?

Terri: As Stacie said, we can’t really comment without looking at specific examples and without having Medical Review here to help with that response. You may submit examples and I will have them reviewed by the appropriate department.

Michelle: It sounds like we are all having the same kind of problems. Thanks.

Sharon: I had the same question about digitized signatures as the previous caller. Could you re-address it? I’m asking about Redeterminations. Can it be digital?

Michael: Yes, that is correct.

Luciano: One last question. As far as denials that are inaccurate, we are a mail order provider and often will receive a denial because we don’t have a beneficiary signature.

The beneficiary signature indicates that the date of service occurred after the claim date. According to the method of delivery and the Program Integrity Manual (PIM), it is not required on our part. Can a denial such as that be reopened or do we have to submit a Redetermination?

Dustin: Are you receiving a Medical Review denial?

Luciano: Yes, after an ADR is responded to. Sometimes the denial will be applied to part of the claim. The claim may be for the test strips, etc., however it does not apply to the lancing device so that confuses me even more because how could a beneficiary sign for part of the order and not the whole order? There is no beneficiary signature on anything that I am submitting. I don’t even know what beneficiary signature they are referring to.

Dustin: You would send those types of denials to Redeterminations. They would not come through the Reopenings Department.

Luciano: OK. As far as the GA modifiers, I assume every time I submit a claim with a GA modifier, I would receive an audit because you are indicating that this item is not medically necessary on the front end. Am I mistaken that sometimes you would be paid for submitting a claim with an ABN?

Michael: The presence of a GA modifier is not what triggers a prepayment review for Medical Review. It is based on the HCPCS codes. They are all service specific prepayment reviews on different HCPCS codes.

Luciano: We get a lot of patients asking for the transcutaneous electrical nerve stimulation (TENS) units for chronic back pain. Without there being any available clinical trials, we give them the option of signing an ABN for the item but I feel like I must tell them that it will likely be denied and be prepared to be responsible for the charges.

Michael: That’s when you should use an ABN because the local coverage determination (LCD) states it is only considered for coverage with clinical trials. You are correct. There are not any clinical trials now so the ABN is appropriate.

Luciano: Right. I was just going off what the lady had mentioned earlier that she was sometimes surprised when she would have to respond to an audit when submitting a claim with a GA modifier because an ABN was on file. It was my assumption that the claim would automatically be audited.

Michael: An audit is not triggered by an ABN. If you want to send Terri a claim example, we will take a look at it.

Luciano: OK. I think if you are indicating that it is not medically necessary, why would it ever be paid without question?

Michael: It is very difficult for us to make general statements about denials and ABNs without seeing what happened with the claim and how the claim was built. That is why we are asking for examples.

Luciano: OK, not a problem. I can do that. That was all.

Teresa: Could you please give me your email address again? I didn’t get the spelling of your last name.
Teresa: We have an ongoing problem similar to the others discussed. It is with faxes for Redeterminations. We have a confirmation fax. I sent some of these back that said ‘redetermination dismissed.’ I have proof that you received it and we have faxes that were received and processed before that fax for the same day within just a few minutes of those. We will just have random faxes that will just fall out of the sky, for example, and are not processed. I will check Mr. Wizard and it shows ‘never received.’ We have ongoing issues with this, three or four at a time in groups. We will find out after-the-fact. We are faxing them days or weeks ahead of the 120 days because we have had to get additional documentation. We don’t find out that it was not accepted until we are checking on it 30 days later for payment or denial and we find out we don’t have a response. A couple I sent for you to review since we had proof of the fax. I get a denial that says you won’t accept it. What is our recourse aside from sending them to you Certified/Return Receipt mail, which I have done in the past? That is a lot of money and it takes longer for you to get it.

Stacie: This is the issue that was brought up at the Council meeting, correct? You had sent in some examples for review to Medical Review?

Teresa: Right. I can send more with the CCN or document control number (DCN) number to see what you can do with them.

Terri: If you are continuing to have fax issues I would appreciate you submitting examples and we can research further.

Teresa: We are continuing to have issues. Tiffany brought me four this week. They called Customer Service and they do not have on file that they received them. I will send those four to you for review. I do appreciate your help.

Sheila: When CMS says there is a contractor error on an ADR or Redetermination, what process does CGS follow for that? We have been having a problem getting them reviewed when we have a contractor error.

Kim: When it comes to Redeterminations, you can contact our Call Center and we can send that back to the Redetermination Department to have it reworked.

Sheila: Your customer service people say that is not what they do. We forego a level of appeal, which we are entitled to, if it is a contractor error.

Kim: When it comes to finding if the Redetermination was done incorrectly, it is difficult for us in customer service because we do not look at the medical records as we don’t have access to those. It is hard for us to determine if it really was denied in error. You probably would be referred to the next level of appeals most of the time. That next level would remand it back to us to have it reworked.

Sheila: So how do you guys meet the CMS requirement that the contractor reopen errors that were made by the contractor? Again, I forego a level of appeals if it is a contractor error. I didn’t know how CGS is meeting that CMS requirement.

Michael: Would you be willing to send an example to Terri about that?

Sheila: I can send you hundreds of examples.

Terri: If you will send a couple examples to Theresa.Shoup@cgsadmin.com, I will see that it gets to the correct department.

Stephanie: A lot of what everybody has been saying we can mimic. Do we all have permission to send you examples on all these different issues?

Terri: Absolutely. If we could get 2-3 examples from each, that would be a sufficient amount for us to research. If this is happening across the board, it may be something that we need to look into on a broader scale.

Stephanie: Would we go direct to our provider outreach representative with examples?

Terri: Send them directly to me. We all work together very closely. We can research those and get them to the appropriate place.

Stephanie: Perfect! Thank you.

Kelly: I have two questions. The first one I am probably reiterating this. I just want to be sure I clearly understand so I don’t do anything wrong on my part. When we get an appeal that is found favorable for whatever code, we will not be getting a written notification stating that subsequent claims will be paid, correct? We will just have to wait for that new remit?

Terri: Yes. If the appeal falls within the serial claims, we will go in and adjust the claims automatically.

Kelly: OK, and the remark code would be the N689 code?

Terri: The N689 code has to do with our mass adjustments relating to the Cures Act, not the serial claims.

The serial claims adjustments are when one denied claim in a series is overturned in Appeals and others have been denied for the same or similar reason. We will go in and automatically adjust all the related claims.

Kelly: OK, so it is automatic? We don’t have to call or write a letter?

Terri: No, you shouldn’t have to. We are currently reviewing claims for the last three years. Does anyone in Appeals or Reopenings want to add anything additional?

Michael: No, we agree with that statement. Regarding the serial claims, I think CMS authorized DME MACs to send letters regarding that. That would be the only situation where Redeterminations would send any type of favorable letters. Everything will be based on your remittance advice statements. As Terri said, for all your Cures Act claims, start looking for the N689 remark code. That will be the way to recognize them. They will be coming in with other claims you are submitting right now.

Kelly: OK. You had mentioned earlier the KE modifier. We have not used that before. We are thinking that for us, it might be the KY modifier. What is the KE modifier for?
Michael: The KE modifier is used with accessories that were for an item in competitive bid round one. This accessory cannot be for a beneficiary that lives in a competitive area.

Kelly: OK, we have never used that so I’m guessing we don’t have to worry about that. Thank you.

Ending

Terri: We do not have any more questions in the queue. I would like to thank everyone for joining us this afternoon. We appreciate you taking time out of your busy day. We will have a transcript of our call today published on the CGS website within the next few weeks. We will also have a ListServ message sent once the transcript is available.

Again, for those who are going to send examples to me, please send those as soon as possible. And as a reminder, please do not send PHI.

Thanks to all who helped with this call. Everyone have a good day.