Kentucky and Idaho Part B Open Forum

Provider Outreach & Education (POE) Advisory Group

CGS Moderator: Vanessa Williams

Operator: Well good day everyone and welcome to the CGS Medicare Part B Open Forum for Kentucky and Idaho conference call. Today's conference is being recorded.

And at this time, I would like to turn the conference over to Ms. Vanessa Williams. Please go ahead, Ms. Williams.

Vanessa Williams: Thank you, Kelsey. Good afternoon everyone and again welcome to the CGS Medicare Services Ask-the-Contractor Medicare Part B Open Forum for Kentucky and Idaho. My name is Vanessa Williams and I am one of the CGS Medicare Provide Outreach and Education Administrator for CGS Medicare Services.

Joining me today to assist with today's Q&A session we have CGS staff from all areas of the CGS Program. Before we have Kelsey open the line for questions we would like to provide you with several important Medicare updates.

The first update that I would like to speak on is the ICD10 updates. We would like to remind you that effective October 1 of 2013 we will no longer use ICD-9 diagnosis codes; we will only accept the ICD10 diagnosis codes.

Please remember that after October 1 of 2013 if your claims are submitted with the ICD-9 diagnosis codes they may be rejected and you will need to resubmit them with ICD10 codes. This could result in delays and may impact your reimbursements if you're not updated with this information.

This change does not affect your CPT coding for outpatients procedures. For additional information and training tools please visit the CMS Web site at www.cms.gov/icd10

I would also like to bring you up to date on the ePrescribing for 2010 incentive. We have started to release checks for the 2010 incentive. If you did participate in the 2010 eReq and you were successful then you should be receiving reimbursement. We will be dispersing these checks up until August 31 of 2011.

Following the disbursement of the incentive checks we will then start the first of the year feedback report in around – the middle of September of 2011.

CMS has instructed all Medicare contractors to use a new indicator of LE to indicate incentive payments as instead of LS. The LE will appear on the electronically remits in an effort to further clarify the incentive payment issued either for PQRI, which is now known as PQRS, Physician Quality Reporting Initiative or Physician Quality Reporting Systems, or the eRegs Incentive. CMS created a four digit code to indicate the type of incentive and reporting year.

For the 2010 eReqs Incentive payment the four digit code is RX10. This code will be displayed on the electronically written advice along with the LE indicator. For example, eligible professionals will see LE, indicated on their remits for the incentive payment along with RX10 to identify that payment as a 2010 eReqs Incentive payment. Additionally the paper remittance advice will read, "This is an ERX Incentive Payment. The year it will not be included in the pay for remittance."

We would also like to remind you that CMS is now accepting registration for the rescheduled CMS Physician Quality Reporting System, and Electronics Subscribing Incentive Program.. This call will take place on Monday, August 29, 2011 and registration is now available
The time of the call will be from 1:30 pm to 3:00 pm Eastern Standard Time. Registration information is available at www.eventsvc.com/palmettogba/082911 , again, www.eventsvc.com/palmettogba/082911 .

If you have additional questions regarding your incentive or payments for 2010 or if you have questions regarding ePrescribing for 2011, in addition to the Physician's Quality Report System Incentive that will be released in mid-October, we ask that you contact the CMS Helpdesk, and it's a provider contact center, which is available at area code 1-866-288-8912.

They're hours of operation are from say it's 7:00 am to 7:00 pm Central Standard Time. This is the Quality Helpdesk and they are available Monday through Friday.

If you would like to correspond with them through the Internet or be it via email, you can contact them at gnetsupport@sdps.org. Again they will be available to assist you.

I am now going to turn this call over to Julene (Mulle). She is our Comprehensive Error Rate Testing contact person with CGS, Ms Mulle would to go over some of the findings regarding the Error Rate program. Julene are you available?

Julene Mull: I am thank you Vanessa. Hi everybody my name, as she said, is Julene Mulle and I am located in the Nashville office. I am the CERT Coordinator for CGS and I would like to take one moment to tell you how excited we are that we introduced to you this week our claim identifier tool.

The Claim Identifier Database (CID) tool is located on our Website and with this tool you can enter your CID number, which is the number that the CERT office gave you when they sent you your notice. And find the results over your CERT review.

If by chance you have misplaced that number or you'd like to see if you've had more than one review enter your Medicare number and you will see all CID numbers related to that Medicare number, it also gives you my contact information. If you have any technical difficulties or cannot find your CID, please contact me and I'll be glad to help you.

We would like to encourage you to continue signing all your documentation, making sure that when you are submitting documentation with regards to lab work or diagnostic tests please include the order and the documentation to support to medical necessity of that.

If you have any questions with regards to CERT please don't hesitate to call me or email me, my phone number is 615-782-4591. My email address is julene.mull@cigna.com and I'll be glad to help you in any way I can. Thanks Vanessa.

Vanessa Williams: Thank you Julene. We are now going to hear from Gloria Lucas, she is our EDI Technical Support Analyst and Gloria is going to give us an update on the ANSI 5010.

Gloria Lucas: Thanks Vanessa. This is Gloria and I just wanted just remind everyone that December 31, 2011 is quickly approaching and that is the date that we accept the last 4010-A1 transactions. As of January 1, 2012 you will have to send your claims in the 5010 Version.

Having said that, we just want to ensure that you have begun your testing process or you have contacted your trading partner to ensure that they have they have begun the testing process.

For those of you in Idaho good news, Blue Cross and Blue Shield Idaho has completed our 5010 and will start migrating their providers to the 5010 format shortly. Also for Idaho providers you will be moving to a new platform for uploading your claims, which is gpnet. So you should have received your information for that already. So again we just want to ensure that you begin 5010 testing so that you will be compliant by the December 31, 2011 date. If you have any questions feel free to call our EDI Helpdesk and that number is 866-520-4022. Thanks.

Vanessa Williams: Thank you Gloria. We are now going to have the Centers for Medicare and Medicaid Services join us to give us an update regarding the provider enrollment changes that are forth-coming.

Mark Majestic: Okay this is Mark Majestic and Zabeen Chong with the Provider Enrollment Group with the - with Medicare. And we're going to talk a little bit today about the revalidation efforts that are ongoing or just commencing around the country.

The revalidation efforts were mandated as a result of the Affordable Care Act of Section 64.1, to be exact. They require all providers and suppliers that are currently enrolled in Medicare to - if they weren't ruled prior to the 25th of March of 2011, and revalidate by the 23rd or March of 2013.

We're just now starting off this process and have issues instructions to contractors to start issuing letters to providers and suppliers within their jurisdictions. How we're going to - the emphasis upon this is do so in a phased approach that will lessen the burden both on the administrative contractors and just as importantly, the providers and suppliers across the country.

Kind of what's behind of - or the - a key thing behind this is we're going to segment out or sequence in the mailings for the next 16 to - 16 to 18 month period. And as I said, "It has to be done by March of 2013."

We're encouraging providers and suppliers to wait to submit their revalidation packets and being instructed by the contractors to do so. This is a key point of our project as it allows, for a couple of reasons, it allows the MACs to better control of their inventories so they can take more time to support, you know, get those resources in there, so they can support this over the long-term, the 16 to 18 month process. And so they'll have the ability to process those applications with the revalidation documents in the time, you know, in a timely manner.

One of the things that's part of this that's unique in this revalidation effort is the interchanges I guess, that we're - that we have instructed the contractors to make the full day - start the process of deactivating a provided as a failure to respond to the revalidation request. What I mean by that is, intimately with providers and suppliers will be sent a revalidation letter notifying them that they have 60 days to submit certain documents.

And prior to that, you know, 60 day completion time there will be repeated phone calls or there will be a couple of phone calls and another mailing to the provider-supplier group to let them know that the, you know, to make sure that they were informed that they have the obligation and the requirement to revalidate.

As I said, "We encourage - once you get the revalidation request we would encourage everybody to respond as quickly as possible to that revalidation request, but wait until notification is made."

Another key point of this whole project is that we are - that the development that's usually done in the enrollment areas has been streamlined. We understand that, and have issued instructions, that if you already have certain documents on file with the MAC's part of your provide enrollment record is that they're going to just take

those. That's there's no change that's made, you know, that they will take the information from those to update your record. But of course you would still need to complete the 855 as requested.

The - another key aspect of this are changes that are going to be made to be to the PECOS system. And they're encouraging people trying to; kind of help us into that system, they will promote the use of that. Instead of sending in paper applications, that they would be able to utilize these enhancements and in a very, going to say, "An easy path method to revalidate."

Those enhancements that are starting to go in -- they won't go in until the January release of PECOS, but in essence what - once they're implemented a provider or supplier, once they get their revalidation request from the MAC they simply have to log into PECOS and then they will be able to see what information is already held in their enrollment record.

And it could be as simple as just hitting a button if I agree everything is correct. And for the most part that would be kind of be 95% of your enrollment process. Other things that are going into place as PECOS enhancements are the ability to sign your application electronically as to where the - it would negate the need to send in certification statements.

So once again, those enhancements aren't going in until after the first of the year.

For the large provider groups they would have the ability to do both uploads of documents from members that are assigned, you know, or reassigning to them. And that will help with those large organizations across the country.

We're encouraging the - that the contractors, and CMS as well, is trying to get as much information about this revalidation effort as what we can. That's why we're very happy that you're asked to participate in this call and hopefully we can answer any question you may have to dispel any rumors or myths or clear up any misconceptions one may have with these project.

We are also planning on sending out throughout, this whole process, different (Medilan) articles, list of messages, speaking at conferences of different types. So we can get the word to out the provider-supplier community with accurate, timely information and to, you know, to try to stay ahead of the of the rumor mill and increase those lines of communication to the maximum extent possible so we can maintain that steady work flow throughout this whole process.

One, we want to keep the provider community informed and in doing so we think we can eliminate or greatly reduce the logjams that could be created if everybody just decided to send their applications in at one time to the contractors because they didn't understand our messaging. So the - I guess that is in a nutshell our revalidation project at a very high level, so.

Zabeen Chong: You know just couple of points to emphasize this.

This is Zabeen Chong from CMS as well. That we are going to be starting with group phase with those that aren't in the PECOS system so if they're only in the local system they will be getting letters first to get themselves enrolled in PECOS.

Two, submitting online is the easiest and fastest way to revalidate. It's easiest for the provider as well as on the MAC and to actually proves that application.

And then just three, as Mark said, "Hold on taking any action until you hear from your MAC." This will allow the MAC to manage their workload and make sure there isn't any type of backlog.

Mark Majestic: But that's all we have for now until the floor gets open up for questions, we'll stick around to answer them.

Vanessa Williams: Okay, thank you very much. Kelsey I'm going to ask that we take this time to go ahead and open up the lines for question, and if you could please give them the instructions on how to address their questions to us.

Operator: Absolutely. Well, ladies and gentlemen, if you wish to ask a question, please press star then 1 on your touch-tone telephone. If you're joining on a speakerphone just make sure your mute function is turned off. And once again, everyone, that is star 1 if you would like to ask a question.

And we'll go to our first caller with Saint Luke's Hospital.

Caller: Hello, thanks for taking my question today. I guess this is just kind of a question in - I hope this signup process to enter the electronic 855A is streamlined. Because I know many hospitals not just me, it probably is easy to enter it electronically, but it's like getting entrance to Ft. Know to get there.

Ms Chong: Right.

Caller: It is just impossible. I have to send correspondence only via the Post Office. It was just difficult. So is that going to be - is that part of the enhancements?

Ms Chong: It is, and I assume you're talking about the authorized official getting that process in place?

Caller: Yes, you not only have to have it authorized, but then once you obtain that then you have to get a security passage to get in, so.

Ms Chong: Yes. So for January, we are also looking at revamping that process and making it easier for those organizations and providers to have someone act on their behalf, and delegate access so that they can use the online system.

Caller: Thank you.

Operator: And once again Ladies and Gentlemen that is star 1 if you would like to ask a question. We'll move on to Shannon Helton.

Caller: Hi. I'm calling from Lexington, Kentucky and I have two questions please. We're receiving a lot of the additional payments from the reprocessed claims from 2010 that were affected by the fee schedule change in the Affordable Care Act, and I wanted to clarify, is CGS's reprocessing of all these claims, is it affecting the regular claims payment floor at all?

Vanessa: I'm going to ask for some assistance on that. From my understanding they are two separate processes. We are continuing to process your claims as you send them in. Not the documents that are that are currently going on based on the 2010 increases. They are separate. Would anybody like to assist me with this one or add on? I think I answered it.
Caller : No I mean it seems like it is negatively impacting and so I wanted to see if anybody could speak on that?
Vanessa Williams: Okay, I'm not sure if you could clarify, are you saying that you're getting a delay in your regular Medicare payments...
Caller: Yes.
Vanessa Williams: and you are submitting your claims electonically.
Caller: Yes.
Vanessa Williams: Okay. Do we have someone from claims to give an update regarding some of the statuses that are going on right now?
(Susan): Hi this is (Susan) from Claims. As far as I am aware, that is correct. The fee schedule payments do not affect the regular payment floor. However I do want to point out that we are in a little bit of a backlog in Claims, so seeing claims taking longer to pay potentially that could be the issue. We are currently adjusting that issue and hope to have that under control shortly.
Caller: Okay. My second question was, we've reached these couple of refund requests so far where it's a very small refund amount, like $19, $14, but there's about 50 different claims listed. And the amount that the individual refund amounts for each claim range from 11 cents to 82 cents, and all that's given is the patient's name and the date of service. So when we call CGS - the first time we called we were told, "Access the list and they would be able to provide more detail as to what's being withheld and why the refund is being requested and what line item it should be applied to on the claim. So we did that and we faxed them a letter asking for that specific information, we called back to follow up and we were told, the only information that they have is that it's a fee schedule issue and that that's all that they can tell us. So my question is, I mean, are we just kind of refunding you all blindly, not knowing why we have to refund this money and exactly which CPT code or line item it's being taken from. And we've asked for the information and we can't get it.

Vanessa Williams: Okay. If it's at all possible could we get some information with you and work with you directly on your case? The information that the call center would have won't be able to retrieve what is going on with the mass adjustments at this time, but we will recapture the information that you faxed in to us, but if I can get your name and phone number. I'm sorry, your phone, then I will give you a call, for a little more additional information. Is that okay?
Caller: Yes
Vanessa Williams: ...and work with you directly?
Caller: what's your name please? I'm sorry.
Vanessa Williams: My name is Vanessa.
Caller: Vanessa, okay.
Vanessa Williams: Okay and I will be giving a call right after our call today okay?
Caller: All right I appreciate it.
Vanessa Williams: We'll get some confirmation from you. Thank you.

Operator: As a final reminder to the audience, that is star 1 if you would like to ask a question. We'll move on to our next caller.
Caller: Hi, I just had a couple questions about the revalidation. The first one is I've been reading in some of the email and (Meyers) articles, there's going to be a $505 fee, does that include those revalidating?
Amy: Okay, It does apply to those that are revalidating for intuitional providers.
Caller: Okay.
Mark Majestic: Yes, that only provides - is only applicable to those institutional providers.
Caller: Okay. Well that - you're talking about the 855A application right?
Amy: Yes.
Mark Majestic: Yes.
Caller: And one other question, we have previously done our applications on paper, and I know the first lady that was on the call mentioned about if our Provider Office wanted to assign one individual person to actually get into PECOS to do those applications, can you guide me through what steps we need to take to be allow that person to do that?
Amy: To become an authorized official? Is this is on behalf - you're talking about on behalf of an organization?
Caller: Right.
Amy: Yes, we can actually send out - there is guidance out on the - I believe on the cms.gov Website that we can send you to...
Caller: Okay.
Amy: That will give you information on how to register to become and authorized official.
Caller: Now does that apply also for like we're a group of ten providers, so if the individual providers needed to revalidate, could the authorized official do their revalidations as well?
Amy: Right now as it stands today, we only have the ability to create an authorized official for an organization, but come January what we're trying to implement is the ability for someone to work on behalf of an individual.
Caller: Okay.
Amy: Additional guidance on that will be coming.
Caller: Okay. So do you have a Web address I need to go to for the group authorized official?
Amy: Yes, let me find that information for you Vanessa. Should I send it through you, is that the best way to do it?

Vanessa Williams: Send it to - through me, or if you would like to

send it through (Phyllis), and I forgot (Phyllis)'s last name. Bear with me one moment, I'm sorry. (Phyllis) are you there?

(Phyllis): Yes. You can send it actually - Amy's in on the call, but it's (Kristina Hamilton).

Vanessa Williams: Okay.

(Susan): This is (Susan) from the Provider Enrollment Department at CGS and I just wanted to add also that the fee does apply to certain organizational structures that are required to complete the 855B also, but those to not enclose physicians or non-physician groups.
Caller: Okay.

Male: But there is a great deal of information on the CMS Website, on the fee actually applies to, because it does boil down to more than just on the 855A. I guess a very general statement and it does boil down - and it defines what an institutional provider is and who has an exception to that. And there's - but there's clear information and guidance already on the CMS Website.
Caller: Okay.
Male: But keep in mind if that fee does apply to you that once you submit the, you know, the application, I mean nothing is going to happen to that application until the fee is actually, you know, been paid.
Caller: Till the fee has been paid, right.
Operator: You're welcome. We'll now hear from our next caller.

Caller: Yes. Could you tell for the State of Idaho, how long will CGS be claims processing MAC for that state? I've heard that there may be a change coming soon. Is there any announcement or something you share regarding that?

Dr. Gary Oakes: This is Dr. Oakes -- go ahead Vanessa.

Vanessa Williams: No you go ahead Dr. Oakes.

Dr. Gary Oakes: Okay, I was just going to say that the RFP has been set out. I understand an award is eminent, however that doesn't mean there won't be protests and further delays. So for the near future we are, but there will be a change coming unless we're lucky enough to have won.

Caller: Wonderful. And will we get a notification of that when it does occur?

Dr. Gary Oakes: Yes, sir, I'm quite sure there will be several list serve messages so stay tuned to that.

Caller: Excellent, thank you very much.

Operator: Our next question will come from (RSIG).
Caller: My question is regarding the IPPE and the AW - the physicals. What happens when a patient is Medicare secondary and they come in for their wellness or their IPPE? Not wellness, but their annual visit. Can we just bypass the commercial and bill it straight to Medicare, because they don't accept the G codes.

Vanessa Williams: Hi and I do apologize to everyone. I had wanted to get the questions to CMS regarding the revalidation, but I did receive two questions prior to this call, because we had offered for you to fax in your questions earlier. Your question was the first one and I'll go ahead an answer it.

You will have to submit the IPPE or the annual wellness visit to the primary based on their guidelines, as far as the services will fall under which CPT codes or which (hixus) codes. Once the primary decision is made then you would forward the service to Medicare secondary payer. You don't want to bypass the primary payer.

Prior to submitting it to Medicare Secondary Payer you will have to change your code to the appropriate IPPE or the annual wellness visit based on your documentation.

Caller: Okay, but then the EOB, the information from the primary will not match the codes that were submitting to Medicare.

Vanessa Williams: Are you submitting paper or electronic?

Caller: Electronic.

Vanessa Williams: Okay, when you submit your electronic information you are only pulling the information based on what the primary pay allowed or did not allow and your new claim information will show the IPPE code or the annual wellness visit code that CMS has developed.

Caller: Okay, great.
Vanessa Williams: So your records will just have documented in the patient's record where it originally went to the primary.
Caller: Okay.
Vanessa Williams: Okay you also had another question, "When is the appropriate way to bill an IPPE or an annual wellness if the provider does not meet the documentation requirements? Is this information on the Medicare Website, and if so, where?" If all requirements are not met as listed under the guidelines for the initial bonus exam or the annual wellness visit then the code cannot be submitted for consideration of payment. For complete documentation guidelines for the IPPE and the annual wellness visits you can visit, and here's the Website for a complete listing of how to document, it's http://www.cms.gov/welcometomedicareexam/ and then that will bring up the overview in addition to your documentation resources.

I would also like to add that on February the 15th of 2011 CMS did issue out a change request, 7079, and it goes through quite a bit of all the documentation based on your exam, what is needed in the patient's record. And that would also be for the annual wellness and the welcome to Medicare. It's a great resource.

Caller: Right and I've seen those resources. I thought I'd seen over something regarding that it's not appropriate to - if the doctor does

not meet the IPPE and the AWV to have it audited and change it to an E&M level code. You know if anything came out about that?

Vanessa Williams: Dr. Oakes I'm going to ask that you help me on this because it is a preventative service then you would have to follow the preventative guidelines that are listed in the (American) Medical Association. But I'm going to ask Dr. Oakes to chime in.

Caller: Okay.

Dr. Gary Oakes: Well I will chime in but I'm going to ask that she restate the question for me so I'm sure I'm understanding what's being asked.

Caller: When the physician does not meet the requirements for the IPPE and the AWV visit, I think I saw something on list serve that stated that it would not be appropriate to audit the visit and change those G codes to a problem E&M. And I was wondering if you guys remembered that, if there is something like that out there.

Dr. Gary Oakes: Well, you know, to me to be billed as an E&M it would have to have the requirements for an E&M...

Caller: Right.

Dr. Gary Oakes: And if the intent of it from the beginning was to be an IPPE or an AWV I think you're going to get some beneficiary pushback when they start getting co-pays and deductibles.

Caller: Right. We have some providers that want it in writing, and so as current we have not been changing them. But okay, thank you so much.

Dr. Gary Oakes: Yes, I think the - and you can take this back from me, that if the intent is to be one of the newer exams, either the IPPE or AWV, they need to meet those requirements or just not bill the visit.

Caller: Okay great, that's what we've been doing.

Dr. Gary Oakes: Great, thanks.
Caller: Thank you.

Operator: And once again, everyone, that's star 1 to ask a question; we'll move on to the next caller.

Caller: Hello. I have a question about the Kentucky Part B local coverage determination, the chemotherapy and biological drug table. And my question is the table attachment is currently not working on the Medicare site. Do you know approximately when that might be fixed?

Dr. Gary Oakes: Well, let me see if I can pull it up, how about that?
Caller: Okay.

Dr. Gary Oakes: You want to move on to another question and we'll come back to this one?

Operator: That's fine.

Vanessa Williams: Hi Kelsey, we are going to come back to this question here. We can go ahead and take the next question.

Operator: No further questions.

Vanessa Williams: Okay. Well please stay on the line one moment.

Dr. Gary Oakes: This should take just a few seconds.

Caller: Okay.

Dr. Gary Oakes: It pulls up for me. It's in a pdf format.

Dr. Gary Oakes: Down at the bottom of the LCD where it says - just above where it says, "All Versions," there's a place that LCD attachments...

Caller: Okay.

Dr. Gary Oakes: (EMO) and biological drug lists and it has the little ((inaudible)) beside it.

Caller: Okay, so I'm not aware of any other contractors that actually does an attached table for their drug coverage. So question related to that is, if you do an update to that drug table how am I going to know?

Dr. Gary Oakes: There will be a list serve message sent out.

Caller: There will be?
Dr. Gary Oakes: Yes Ma'am.

Caller: I don't see a revision history.

Dr. Gary Oakes: That's because there's not a revision history.

Caller: Okay.
Dr. Gary Oakes: This stuff has not been revised.
Caller: Well when I look at the future -- LCD is marked future at this point -- there appears to be updates to the Drug Table, but no revision history.
Dr. Gary Oakes: Okay...
Caller: And I'm speaking about CMS's site.
Dr. Gary Oakes: I'm looking here where there's revision history explanation and there's seven revisions listed.
Caller: So am I looking in the wrong place?
Dr. Gary Oakes: Well you probably are.
Caller: I've got the LCD in front of me via the CMS's Website, the L31836.

Dr. Gary Oakes: It's the first one, down at the bottom of - under General Information, about halfway down it starts revision history.
Caller: Okay.
Dr. Gary Oakes: There's only been a couple, one of them being (Pravenge) that we added in. But any time we make a coverage change it - if it's in one of the article we would not necessarily do an LCD revision, but there will be a list serve any time we change coverage whether it's to restrict it or to liberalize it.
Caller: Okay. My issue is I looked at the Drug Table, and I have a pdf of the Drug Table from about a week ago and I see where the information for (Pravenge) just now changed, but the effective date is 4-30-2011.
Dr. Gary Oakes: Right, we have that option to make it retro.
Caller: Okay, so I can - that's what my problem is. I'm looking at the date thinking that's an old revision. Okay.
Dr. Gary Oakes: Don't do that.
Caller: Well.
Dr. Gary Oakes: When there's a change that we think needs to be covered back I usually don't go beyond the first of the year, but you know, for fairness to the provider who was filling it in, you know, appropriately...
Caller: Right.
Dr. Gary Oakes: ...let's say, then a lot of...
Caller: Right.
Dr. Gary Oakes: times we will - I can make them retro.
Caller: Yes.
Dr. Gary Oakes: Actually newer drugs we don't do that. But the NCD became effected on that - effective on that date. So that's why we retroed (sic) it back to then.
Caller: Right, right and I understand that and appreciate that, my problem is I can't tell when the revision was done because it itself is not dated. Do you know what I mean?
Dr. Gary Oakes: Well.
Caller: Like I can understanding backdating it, but I can't tell when the update was done.
Dr. Gary Oakes: Okay. Well I can ask our person to put that in there. It's actually on our database when we go in where we do the revisions. It's actually there and it will show the date, but it does not show up here. You are correct.
Caller: That would really help me. I would truly appreciate that.
Dr. Gary Oakes: Well I'm say sugar and send candy and do all that other and see if they'll do that for us.
Caller: Thank you Dr. Oakes.
Dr. Gary Oakes: Thank you, appreciate you calling in.
Operator: Ms. Williams, no further questions.

Vanessa Williams: Okay. I would like to take this opportunity to thank everyone for joining us today and all of the CGS staff in addition to the participants from Idaho and Kentucky. We will look forward to working with you in the near future. And if you have any further questions or concerns please be sure to contact our call center for assistance. Thank you everyone and have a good day.

Operator: And again, ladies and gentlemen, that does conclude our conference for today. We thank you all for your participation.

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