

**Centers for Medicare & Medicaid Services**  
**DME MAC CERT Education Task Force National Call**  
**Moderator: Shana Olshan**  
**January 13 2010**  
**2:00 p.m. ET**

Operator: Welcome to the DME MAC CERT Education Task Force Ask-the-Contractor teleconference. All lines will remain in a listen-only mode until the question and answer session. Today's conference is being recorded and transcribed. If anyone has objections you may disconnect at this time. I will now turn out conference over to Ms. Shana Olshan with Centers for Medicare & Medicaid Services. Ma'am, you may begin.

Shana Olshan: Thank you Christie. Please switch to slide 2. Thank you everyone and welcome to the first in what we hope will be a series of collaborative contractor education offerings by the DME Medicare Administrative Contractors on the comprehensive error rate testing program which you all probably have heard referred to as CERT. My name is Shana Olshan and I am the Division Director for the Division of Contractor Provider Communications at the Centers for Medicare & Medicaid Services.

Today's call is being recorded and will be offered as an encore presentation available on all four DME MAC websites in the next one to two weeks. You will receive a listserv message from your DME MAC letting you know when the encore recording, FAQs, and written responses to your questions are available.

Today's Ask-the-Contractor teleconference will introduce you to a new initiative which has been created and implemented by your DME MACs in Jurisdictions A, B, C, and D. Their goal is to work together to improve knowledge and performance related to the CERT program and to centralize education to present a single educational message to suppliers throughout the United States.

This unique approach to education first came to our attention here at CMS when contractor executives from all four DME MACs met with us to discuss the impact that additional review findings were having on Medicare suppliers. What resulted was a collaboration of all DME MACs and the formation of this MAC CERT Education Task Force.

Since March, 2009, the task force has been developing focus education on the CERT Program which we believe will have a positive impact not only on the reduction of common errors but will also support our need to reduce inappropriate payments for those errors.

As we've all seen over the past few months, there is an immediate need to reduce fraud and abuse in the Medicare program. As part of the Obama administration's goal of reducing waste, fraud and abuse in Medicare, the Department of Health and Human Services and CMS significantly revised and improved the calculations of Medicare Fee-For-Service error rates in 2009.

As suppliers of medical equipment you've already seen how these improvements have led to increased review of your claims and increased requests for additional documentation to support payment of those claims. Education developed by the DME MAC CERT Education Task Force has been designed to help you avoid the very errors which continue to generate improper payments as well as reviews of your claim by the CERT contractors.

While improper payments are not necessarily an indicator of fraud in Medicare or any other federal health care program, they do provide those of us with fiscal responsibility for oversight of the trust fund, a more complete assessment of what errors are recurring and how many errors need to be fixed. And that is where the DME MAC CERT Education Task Force plays an important role.

I am very excited about this task force because I believe that having the MACs work together in this way will help improve the consistency of information that suppliers receive thereby improving the education, reducing incorrect billing by suppliers and improving the overall care for the Medicare beneficiary.

Please take advantage of the collaborative educational efforts that this task force has already developed and will continue to do so in the future. And slide 3 please – so here to introduce you to the task force and their collaborative educational initiatives for 2010 is John Kelly with CIGNA Government Services.

John Kelly:

Thank you Shana. Hello everyone. I'd like to thank CMS for not only providing the forum for today's call but for also sharing our vision for consistent education in support of reduced errors, waste, fraud and abuse of the Medicare program. I'd like to take just a moment to explain how today's call will work.

Representatives from all four DME MAC contracts will present information specific to the CERT program and they will provide you with a lot of very valuable information. References and additional education opportunities will be available to you at the conclusion of today's call.

I'd also like to let you know that today's call is not a forum to discuss specific claim issues. Our focus today is on the launch of a new multi-DME MAC contractor initiative to support you and CMS in reducing errors identified through the improved comprehensive error rate testing or CERT process.

For purposes of introducing new CERT education initiatives, we do not have medical director representation on today's call. We do plan, however, as part of our comprehensive education strategy to provide opportunities in the near future to conduct education that will include medical director education related to CERT.

Slide 4 please – joining us today are Dawn Hermes, with the NGS Provider Outreach and Education Team serving Jurisdiction B, Jody Whitton, Education Representative with Noridian Administrative Services for Jurisdiction D, Denise Winsock, Provider Outreach and Education for NHIC and Jurisdiction A, James Herron, CIGNA Government Services Provider Outreach and Education for Jurisdiction C and Amy Capece, PCSP and Outreach Education Manager for NHIC also serving Jurisdiction A. Together, we represent the 15 members of the DME MAC CERT Education Task Force.

Moving on to slide 5. During today's call we will introduce you to the task force and learn what CERT is and how it is performed. We will also talk extensively about medical records requests and the importance of responding to those requests. We will provide information on the CERT appeals process, provide education on the most frequent errors across the country and then provide you with valuable resources for additional information.

Slide 6 please. The DME MAC CERT Education Task Force is unique to the Medicare program. It is the first multi-contract collaboration since the implementation of the Medicare Modernization Act of 2003, which mandated competitive bidding for all Medicare business. It is also unique in that it is the first time contractors have worked together to develop a consistent educational message for all Medicare suppliers that is focused specifically on the CERT program.

The value of the task force was introduced to Medicare contractors at the Provider Customer Service Program Conference in October of 2009 and participants at the Medtrade East Conference in Atlanta were given a preview of our education during a special workshop. Today you will learn how our focused education will help you so you can begin reducing common errors.

Slide 7 please. That's the history of who we are and what we plan to accomplish as we develop a unified consistent educational message on the CERT program. And now here to talk with you about the CERT program and how it is performed is Dawn Hermes with Jurisdiction B. Dawn.

Dawn Hermes: Thank you John. On slide 8 – the Centers for Medicare & Medicaid Services implemented the comprehensive error rate testing program, otherwise known as CERT, to comply with the Improper Payments Information Act of 2002. The first CERT improper payment report was published in November of 2003.

The main objective of the CERT program is to protect the Medicare Trust Fund. To do this, CERT reviews randomly selected claims for accuracy of the claim submission, processing and payment, therefore ensuring that claims submitted to the Medicare program are coded and paid according to the Medicare guidelines.

CERT releases a biannual report to provide suppliers, contractors and CMS with their results. These reports are usually released in November and May. The results, along with the contractors' internal breakdown of the CERT data, are used to help develop appropriate educational material and to determine local, regional and national error rate patterns.

Incorrect payments take money from the Medicare Trust Fund. CERT finds the incorrect payments and restores the trust fund. This information is used by CMS and the contractors to prevent future improper payments. On slide 9, this shows how CERT is performed.

The CERT documentation contractor or CERT DC is responsible for requesting medical records. Once the randomly selected claim has finalized, the CERT DC will request documentation. The documentation is then scanned and sent to the CERT review contractor to determine if the service or treatment documented is the service or treatment billed and that the documentation supports medical necessity.

CERT does provide a Web page, which is [www.certprovider.org](http://www.certprovider.org). Again, that's [www.certprovider.org](http://www.certprovider.org) for suppliers so that you can update your contact information. You may also call the CERT DC customer service line at 888-779-7477 - again, the customer service line is 888-779-7477 - and ask them to make the updates to their system.

The information that the CERT DC needs to make sure that they can contact you correctly are a correct mailing address, a correct phone number, a correct fax number and your provider ID. And if possible, a point of contact who may be responsible for gathering your documentation requests. On slide 10, once the documentation is received, the CERT DC scans the records and supplies them to the CERT review contractor or the CRC.

AdvanceMed has a medical director and licensed medical professionals who review the documentation. They use local coverage determination and CMS Medicare guidelines to make their determination as to whether the service has been paid correctly or if an error exists. Biannually in May and November,

the CRC gathers the data from the reviews and uses it to calculate the error rates.

Slide 11 explains what is contained in the letter of request for medical records. The request will always contain the official CMS logo, which you will see on the next couple slides. The letter will have identified a beneficiary for whom CERT is requesting medical records. You will find a bar coded cover sheet enclosed with a letter which includes the control number, a patient's name, provider type, and contractor type as well as the CID number.

Each control number corresponds to each identified beneficiary and each beneficiary will have their own CERT identification or CID number assigned. The CID number is how CERT protects personal health information and how they track the medical records once they receive them. The letters will instruct you on what type of documentation is needed and how to submit the documentation to the CERT DC.

Suppliers are being asked to supply records in accordance with all Medicare guidelines, not just local coverage determination. As it is stated in the Program Integrity Manual, however, neither a physician's order nor a CMN, nor a DIF, nor a supplier prepared statement, or a physician attestation by itself provides sufficient documentation of medical necessity.

Even though it is signed by the treating physician or supplier, there must be information in the patient's medical record that supports the medical necessity for the item and substantiate the answers on the CMN if applicable or DIF if applicable or information on a supplier prepared statement or physician attestation if applicable. The CERT contractor is reviewing records to substantiate the answers provided by the physicians.

On slide 12, this will show you an example of the first CERT request letter. It is basically giving you a brief description of what CERT is, notifying you that your business has one or more claims that have been randomly selected for the review, that responding to this request in no way violates the HIPAA Act and most important that failure to respond to this request will result in an error and the recoupment of money.

On slide 13, this shows you what the barcode coversheet looks like. The barcode in the middle of the sheet shows the CID number. This sheet is to be placed in front of the medical records submitted so that the CERT DC can use the CID number to track and identify the beneficiary to the correct records.

Below the barcode is a list of documentations the CERT contractor may require to help support the medical review of the claim. They ask for any pertinent medical records and any additional documentation that you feel may help to support the claim for the specified dates of service and specified bene.

They also remind you to copy both front and back of all records and to make sure that you do not cut off any of the records' edges. Please review your copies for legibility and completeness prior to submission to the CERT documentation contractor.

And finally on slide 14, this shows you a copy of the envelope that the requests arrive in. You should place this as a high priority as to respond in a timely manner to any of the CERT requests that you receive. The time limit to respond to CERT is 75 days. Again, I would like to remind you of the importance of responding to the CERT contractor.

Please verify that the address, phone number and point of contact are up to date in our systems or on the Web page portal. Thank you and now James Herron will talk to you about responding to the CERT questions. James?

James Herron: Thank you, Dawn. My name is James Herron and I am a Provider Outreach and Education Representative for CIGNA Government Services and Jurisdiction C. This is slide 15. I'm sorry. Now let's move on to slide 16.

It is the supplier's responsibility to one – obtain the documentation needed to support the medical necessity of the equipment being supplied. If the physician does not provide you with the documentation that you request, you can explain to them that it is stated in the Program Integrity Manual, for any DME POS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement if applicable.

The information should include the patient's diagnosis and other pertinent information including but not limited to duration of the patient's condition, clinical course, whether it's worsening or improving, the prognosis, nature and extent of functional limitations, other therapeutic interventions and results of past experiences with related items, et cetera.

It also states there must be information in the patient's medical record that supports the medical necessity for the item and substantiate the answers on the CMN or DIF if applicable or information on a supplier prepared statement or physician attestation form if applicable.

If the physician continues to refuse to cooperate with your request for documentation, you could always inform them that your company will not be able to supply the equipment as ordered until this information has been provided. CMS also considers it the responsibility of the supplier to ensure documentation of this medical need can be obtained and forwarded to the appropriate contractor within the specified time frame.

If your business has multiple locations but you would prefer all CERT requests are mailed to a specific location, you may update that information at the CERT contractors' website which is [www.certprovider.org](http://www.certprovider.org). Again, that's [www.certprovider](http://www.certprovider.org) – that's one word – dot org. Let's move on to slide 17, please.

Let's review some of the rules and regulations that apply. For any item to be covered by Medicare, it must one – be eligible for a defined Medicare benefit category, two – be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member and three – meet all other applicable Medicare statutory and regulatory requirements.

For the items addressed in this medical policy, the criteria for reasonable and necessary are defined by the following indications and limitations of coverage and/or medical necessity. Slide 18 please.

Upon reviewing the documentation requirements, we remind you that the Social Security Act precludes payment to any provider of services unless there has been furnished such information as may be necessary in order to determine the amount due such provider. It is expected that the patient's medical records will reflect a need for the care provided.

The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be made available upon request. Slide 19 please.

So what medical records are necessary? To help determine that you should ask yourself if the items fit a Medicare benefit category or whether the item is medically reasonable and necessary. You should ask if there is documentation to support the item and whether the item is coded and billed correctly and that's just to name a few. And note, we do have others listed on this slide.

On slide 20 you'll see that the next question to ask is what medical records are necessary? The documentation sent to the CERT review contractor should include information such as the patient's diagnosis, duration of the patient's condition, whether the clinical course is improving or getting worse, the nature and extent of any functional limitation and prognosis just as an example.

To verify the appropriate coding, the PDAC is an excellent resource. You can obtain additional information from their website at [www.dmepdac.com](http://www.dmepdac.com). And again, that's <http://www.dmepdac.com> or by calling 877-735-1326. 877-735-1326. You may also refer to the supplier manual, LCD and policy articles and your contractor's website for additional coverage information.

On slide 21 please – there may be times when due to unusual circumstances, your documentation may be lost due to a disaster such as a hurricane. It is important to note that even if your documentation is compromised, you are still obligated to respond to requests for this information.

You should complete the disaster attestation form and return it with the barcoded sheet Dawn referenced on slide 13. This will alert the CERT

contractor to your particular issue and may result in no error being called on the claim or the claims that are under review. The disaster attestation form can be found at <http://www.certprovider.org> and again, that's [www.certprovider.org](http://www.certprovider.org). Slide 22 please.

There are three ways to respond to a request from the CERT contractor and that's by fax, mail or you can put records on a CD and mail that to them. We have provided that information for you on slide 22. You're encouraged to keep this contact information for future use. It is also available on all DME MAC websites as well as the CMS website, should you need it at a later date. Slide 23 please.

Keep in mind that you are entitled to appeal a CERT determination. Once the overpayment letter is received, requesting the re-determination within 30 days will help avoid an offset. When requesting an appeal for CERT recoupment, it is helpful to include a copy of the CERT overpayment request with your appeal.

Keep in mind, you do have 120 days to submit your request and it must be submitted in writing. For additional information on this, please visit your DME MAC contractors' website. All DME MACs have extensive information and education available on the appeals process. Slide 24 please.

Now let's talk about the common errors in the CERT program. The DME MAC CERT Education Task Force has identified the top six most frequent errors across the United States. These top errors are based on analysis of CERT data. Those areas with the most errors are oxygen, diabetic supplies, power mobility devices and wheelchairs, nebulizers and drugs, enteral nutrition and positive airway pressure devices. Slide 25 please.

While recent program changes have generated a lot of discussion regarding submission of oxygen claims, the primary reason for errors are incomplete medical records and lack of physician documentation to support payment. As is written in the LCD, or the local coverage determination, you are reminded that in a review you may be asked to provide a copy of the actual test report

and/or information from the medical record to verify that coverage criteria have been met.

Of particular importance is your ability to prove through medical records and documentation that the patient has been seen and evaluated by the treating physician within 30 days prior to the date of initial certification. This is outlined in the oxygen policy.

We recognize that it may sometimes be difficult to obtain the information you need from the treating physician. In those cases, since payments of your claims are impacted, you'll need to insist the treating physician provide you all required information before submitting a claim.

You should also ensure that documentation contains a legible physician identifier in addition to all of the required data such as beneficiary history using oxygen, clearly documented saturation test levels, et cetera. Now at this time I'll ask Jody Whitton to share some helpful information on diabetic supplies and power mobility. Jody.

Jody Whitton: Thank you James and now we're going to move on to slide 26. Again, my name is Jody Whitton and I'm an Education Representative for Jurisdiction D DME MAC.

I am going to speak about documentation requirements for diabetic testing supplies and power mobility devices and wheelchairs and what the CERT contractor is finding as insufficient or missing documentation. I'll be covering a lot of information on the next two slides, so, just to warn you. As a reminder, all the DME MAC contractors as James has mentioned have information published on their website for you to review. Let's go to slide 27.

So first off, let's talk about diabetic supplies and how the physician order is incomplete or missing. A common theme with a lot of CERT errors, revolve around the order. Most durable medical equipment, prosthetics, orthotics and supplies may be dispensed based on a verbal dispensing order. We sometimes refer to this as a preliminary order as well.

Make sure that initial order is well documented within your place of business and has enough elements for you to appropriately dispense the item that's being prescribed. At a minimum, be sure to document a description of the item, the beneficiary's name, the physician's name and the start date of that order.

Also make sure that the order comes from an individual qualified and authorized to order DME POS items – a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant. If you dispensed an item based on a preliminary order, you must follow up with a completely detailed written order prior to claim submission.

For diabetic testing supplies this must include all items, the specific frequency of testing, the treating physician's signature, the date that the treating physician signed that order and the start date, especially if it's being dispensed based on that preliminary order.

An order that only states as needed or PRN will result in a review as being denied as not medically necessary. A new order needs to be obtained when there is a change in the testing frequency. So that's something important to note as well. Now let's move on to the beneficiary's testing log and justification for the testing frequency.

The quantity of testing strips, lancets, replacement lens shield cartridges that are covered by Medicare is determined by whether the beneficiary is being treated with insulin or not. For beneficiaries who are being treated with insulin, Medicare allows up to 100 test strips, 100 lancets, and one lens shield cartridge every month.

For beneficiaries who are not being treated with insulin, Medicare allows up to 100 test strips, 100 lancets, and one lens shield cartridge every three months.

There's additional coverage criteria that must be met if the treating physician feels the beneficiary needs to test more often. One of those criteria is there must be proof that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. That proof can

come from the physician's records, such as maybe a narrative statement in the beneficiary's medical record or maybe that physician has the actual testing – beneficiary's testing log or it could come from supplier's records as well. Maybe the supplier has a copy of the beneficiary's testing logs. So be prepared to provide this documentation if requested.

For patients testing above the policy limit, not only do you need an order for the testing that exceeds the guidelines but the treating physician has documented in the patient's medical record the specific reason for the additional material for that particular patient. Again, be prepared to provide this upon review as well.

No physician medical record to support the diagnosis as you know glucose monitors and testing supplies are covered by Medicare for persons with diabetes. That would be an ICD-9 code range of 249.00 through 250.93. Not only does the ICD-9 code on the claim that you submit need to fall within that range but it must be supported by medical records. So be prepared to provide those medical records again upon request.

No documentation to show testing as prescribed or beneficiary is not testing as prescribed or conflicting documentation – suppliers must not dispense a quantity of supplies that exceeds the beneficiary's expected utilization. Suppliers need to stay attuned to the atypical utilization patterns on behalf of their clients and verify with the ordering physician that that atypical utilization is in fact warranted because if it's not, you may need to go back and get you know, another order to justify that.

An order refill does not have to be approved by the ordering physician if it's still currently valid. However, a beneficiary or their caregiver must specifically request refills of testing supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined basis. Even if the beneficiary has authorized this in advance.

As referenced in the CMS Program Integrity Manual, contact with a beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery shipping date. For subsequent

deliveries for refills – of refills, the supplier should deliver DME POS product no sooner than approximately five days prior to the end of the usage of that current product.

Finally, I'm almost there, no legible physician identifier – Medicare contractors require a legible identifier for services that are provided or ordered. It further requires that when the documentation is for medical review purposes, the only acceptable method of documenting the provider's signature is by written or electronic signatures. Signature stamps are not acceptable to sign orders or other medical records for medical review purposes. Now on to slide 28.

Let's talk about power mobility devices. In the previous slide, I mentioned that most DME POS items can be dispensed based on a preliminary verbal dispensing order. Power mobility devices however are not one of those items. The PMD policy has very specific requirements when it comes to a face-to-face examination, the order, which we refer to as the seven-element order, the detailed product description, home assessments and medical records. So please make sure you read that documentation section of the LCD very carefully as well as the policy article regarding the face-to-face examination.

Some of the CERT areas of concerns are there's no physician documentation of mobility limitation to support that the medical need for the equipment, no physician documentation justifying the power option is needed over a manual wheelchair and no physician face-to-face is documented at all.

So prior to dispensing a PMD, the beneficiary must have a thorough face-to-face examination with their treating physician to assess the patient's need for the power mobility device and what device will help that beneficiary to complete their mobility related activities of daily living – feeding, grooming, that kind of stuff.

The physician may refer the patient to a licensed certified medical professional. This referral can take place before or after the physician's face-to-face examination but it does not take the place of that face-to-face

examination with a treating physician who's going to complete that seven-element order.

The evaluation should be tailored to the individual patient's condition. The history should paint a picture of the patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulties or impact on the beneficiary's ambulatory abilities.

Another area of CERT concern is that the patient is ambulatory and doesn't qualify for the wheelchair or the PMD. Although patients who qualify for coverage of a PMD may use that device outside the home, because Medicare's coverage of a wheelchair or a PMD is determined solely by the patient's mobility needs within the home, the examination must clearly distinguish the patient's ability and needs within the home from additional needs for use outside the home.

So again, refer to that LCD and make sure all the basic coverage criteria are met for the wheelchair or the PMD as well as specific coverage criteria based on what is going to be dispensed to that beneficiary. Additional coverage criteria for wheel chairs and power mobility device options and accessories can be located in that particular LCD and policy article as well, which is titled Wheelchair Options and Accessories.

I realize I have shared a great deal of information relating to diabetic supplies and power mobility devices but again, I encourage you to visit your contractor's website for detailed information and what education is available. And now to speak about nebulizers and drugs, enteral nutrition and PAP and supplies is Denise Winsock from Jurisdiction A. Denise.

Denise Winsock: Thank you Jody. I'm going to review the next three policies, which CERT has cited for missing documentation. And slide 30. The next frequent CERT errors for nebulizers and nebulizer drugs, which commonly deny for the following reasons – missing documentation to support the reason for the airway issues and current need. The nebulizer LCD lists the specific ICD-9

diagnosis codes, which qualify a patient for a specific nebulizer drug. Be sure the drug that is provided is covered for the patient's specific diagnosis.

Next, no documentation was provided such as chart notes to indicate that the patient is compliantly using the nebulizer as prescribed. Documentation supporting medical necessity is missing or does not support the need for these items. Such documentation would consist of the order, the patient's medical record, and the pertinent diagnosis codes and again, this list is not all inclusive. Documentation is missing that identifies the continued need for the specific types of medication and/or their frequency.

The treating physician should have ongoing records to show the continued need for the nebulizer and drugs and the patient's compliance to the treating physician's treatment plan for the aerosol treatments. And another common reason – or excuse me – error for not submitting a valid physician order, the order for any drug must clearly specify the type of solution to be dispensed to the patient and the administration instructions for the solution.

The type of solution is described by a combination of A – the name of the drug and the concentration of the drug in the dispense solution and the volume of solution in each container, or B – the name of the drug and the number of milligrams or grams of drug in the dispense solution and the volume of solution in that container.

A new order is required if there is a change in the type of solution dispensed or the administration instructions. For all inhalation drugs, a new order is required at least every 12 months even if the prescription has not changed. Missing this type of detail results in an invalid order.

And lastly, an order that is signed after the claim was submitted is not valid. A valid detailed written order must be received prior to claim submission. If not, the claim must be submitted with an EY modifier. And it is extremely important that you refer to the documentation section of the specific LCD for a complete list of documentation requirements. Slide 31.

The next policy is enteral nutrition. The common errors for this policy that have been identified by CERT include the following – the requested

documentation was not submitted to CERT. Please be sure to respond timely to all CERT requests and to provide the requested information.

For records that were submitted, many were insufficient to show the medical need for nutrition initially or the continued need for the nutrition based on the date of service in question. Specifically, clinical documentation to support the qualifying specific medical condition and need for the special nutrient.

The DME Information Form or DIF was not submitted for review. The DIF is required for enteral supplies and must be submitted with a CERT request. The DIF for enteral nutrition is CMS form 10126. And finally the order for the pump and/or supply kits was not submitted. Items billed before a signed and dated order is received by the supplier must be submitted again with an EY modifier. This modifier must be added to each affected HCPCS code.

And to avoid these common errors identified by CERT, this documentation must be provided in the event that the CERT contractor contacts you requesting documentation on your enteral claims. Slide 32.

Our last policy groups is positive airway pressure and supplies or PAP and claims have been cited for not having the following information – there is no documentation showing that the beneficiary is compliantly using the PAP device; sleep study documentation was not submitted with the request; documentation of a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea; physician notes documenting the continued need for the PAP device were not submitted; physician notes proving medical management of the patient were missing; the physician order was either not submitted or was invalid as a result of not having a physician's signature on the order. And remember that stamped signatures are no longer acceptable. Detailed written orders may take the form of a photo copy, a facsimile image, electronically maintained or original pen and ink document. And this does apply to all orders, not only PAP. And it is not uncommon for the provider outreach and education teams to frequently get asked if providers need to have all the required chart notes and documentation in their patient's files prior to submitting their claims to Medicare. The answer that is typically given is that, well it's not required. It

is highly recommended that you obtain this information up front because it will help you to determine if there is sufficient documentation available to support the services you are about to render. And by obtaining the documentation sooner rather than later, you can gain confidence that when a claim is chosen for CERT, you will have access to all necessary documentation and the documentation will be sufficient to support the need for the equipment or services provided. And here to summarize our education and prepare for us questions and answers is Amy Capece - from Jurisdiction A. Amy?

Amy Capece: Thank you Denise. I'm Amy Capece, the Provider Customer Service Program Manager for NHIC, your Jurisdiction A DME MAC. On slide 34, as we conclude our CERT education and prepare for questions, we want to remind you that improvement in CERT results requires each of you to take action. You've heard a lot of information during the presentation today and one of the things that has been repeated several times is it is highly recommended that you obtain all related medical records early in the process.

All DME MACs will have a suggested intake form on their website to help ensure the records you receive and retain are complete, legible, signed and contain all information, including the front and back pages of all support documentation. It is very important that you respond to CERT requests. Failure to respond is not acceptable and only delays resolution of the error. It is best for you to retain documentation for at least seven years.

Finally, always keep your information current. You may update your contact information at [www.certprovider.org](http://www.certprovider.org) and if you need assistance to update your information, you may call the CERT documentation contractor at 301-957-2380 or toll free at 1-888-779-7477. We have provided you with all website and telephone numbers from this call on the last two slides of the presentation. Slides 35 and 36.

Each of your DME MAC contractors has extensive information on the CERT program including customized education. We encourage you to visit our website and to sign up for our listserv so you receive updates on new

information and education that is available and we have provided details on each of the DME MACs websites on slides 35 and 36. Slide 37.

That concludes this portion of our CERT education and before we open the lines up for your questions and comments, we would like to respond to some of the questions we received in advance of today's call.

Prior to today's call, we received in excess of 100 pre submitted questions and certainly while we would like to verbally respond to all of them we simply did not have the time on today's call. We did do our best to try to address as many as possible as part of our presentation today and we will also be publishing an extensive list of questions and answers on all of our contractor websites along with an encore audio presentation of the call. So please be sure to monitor your listserv messages for the publication date and information.

Several of you asked what the reasoning was for the recent reviews. As Shana Olshan from CMS mentioned at the beginning of our presentation, all of us are tasked with reducing waste, fraud and abuse of the program. Increased reviews provide CMS with information needed to monitor errors so they can decrease improper payments from the Medicare trust fund. Slide 39.

Another common question – we've received several questions regarding the key elements discussed during a review. The best thing to remember is to have complete documentation to support the medical necessity and proof that the coverage criteria is met. We cannot emphasize that enough. Also be sure to illustrate that the appropriate codes and guidelines have been followed.

On slide 40 – perhaps the most common question that was asked was how to respond to requests for documentation that is not listed in the LCD or the local coverage determination. Documentation is your best friend. At the core of the program is the requirement included in the Social Security Act that says that it is expected that a patient's medical record reflect the need for the care provided. At the most basic level of everything you do, document, document, document. And again, cannot emphasize that enough.

On slide 41 – we want to thank you for the pre-submitted questions. As a reminder, we will publish an extensive list of the responses to all the questions

that were received on all the DME MAC contractor websites. We will now prepare for your questions. Please be sure when asking questions verbally to identify yourself and tell us who your contractor is before asking your question. Please just be sure to identify in which jurisdiction you are so that we can appropriately answer your question.

As a reminder, we do not have medical directors on today's call so we will not be able to respond to questions regarding LCDs or coverage determination. We also cannot respond to claim specific issues you may be having. As a reminder you should reach out to your contractor contact center for assistance with those types of questions. Now so that we may take our remaining time to answer some of your questions, we will ask our operator to guide you through that process.

Operator: We will now open the lines for a question and answer session. To ask a question, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question. Also please pick up your handset before asking a question to ensure clarity. Please note your line will remain open during the time you are asking a question. So anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Victor Lopez. Your line is now open.

Victor Lopez: Yes good morning. Can you hear me?

Male: We can. Hello.

Victor Lopez: Yes, Victor Lopez with Hartman Brothers Incorporated, we – our provider in Colorado is CIGNA Government Services and we're – claims go to the DME MAC region C. The question that I have is a situation where there's been a change of request or some kind of documentation that alters the LCDs. Somewhat the scenario would be the new reasonably useful lifetime. Those particular – especially with oxygen, those claims sent with the first month of RRRRA modifiers. We've run into a situation where they didn't want to budge on the fact that the patient had not been seen and the testing had not been done

within the 30 day window and yet there was a change request and other direction from CMS that stated that that wasn't required in that particular situation. How should that be addressed?

James Herron: Hi Victor. This is James Herron. How are you doing?

Victor Lopez: Good James. How are you today?

James Herron: I'm doing well, thank you. Let me make sure I do understand – you're referring to the replacement of oxygen when there's been a – that the five years reasonably useful lifetime has ended and you are then replacing oxygen. Is that correct?

Victor Lopez: That is correct.

James Herron: And really there, you know that is correct in that situation and you know specifically speaking to the five years, you are not required to have a retest by the physician. All you would simply have to do is have the physician complete a new CMN and you can treat that really as an administrative document. Your medical need was already established with your first CMN set which would be your initial and your re-cert and now after five years you are just you know re-upping that for another you know reasonable useful lifetime period. So all you'd need to do is just have your administrative document which would be that initial CMN which then would need to be re-certified at whatever the particular time frame is. Are you speaking more to concerns about education on that?

Victor Lopez: Well, my main concern is in a CERT audit, when that scenario arises, are the people that are looking the CRCs or these particular people that are doing the CERT audits, how up to date are they on the changes that CMS is making because I mean, this is a moving target and this program changes frequently and it seems like sometimes there's this disconnect between what CMS has said and how the providers are doing and what they're requesting.

James Herron: That's a good question, Victor. Thank you. But as far as the level you know like say on target with CMS, the CERT review contractors and the CERT

contractors in general are you know they are aware of all the rules then you know in place by Medicare so they should be right on target with that.

Victor Lopez: OK.

James Herron: OK.

Victor Lopez: That answers it. Thank you.

James Herron: Thank you, Victor.

Operator: Your next question comes from the line of Jerry Francisco. Your line is now open.

Jerry Francisco: Thank you. My name is Jerry Francisco and I am representing Apria Health Care and we deal for all four DME MAC and my question is in reference to specifically the oxygen claims that are being audited through the CERT program. This is a two part question and firstly is sometimes we would have patients in which the initial CMN was done 11 years ago – say in 1999 and of course the date of the test was in that time frame. It was re-certified therefore in 2000 and we received a CERT request today for a current date of service for example. Let's say for the oxygen fills. So therefore part of the question or part of the CERT request would be a copy of the test and often times when we go to the physician's office they say that they do not retain records from that far – from that time frame. So we would like to find out is that type of a denial because what will happen is that we will get a recoupment. We would like to know if that is a denial that can be appealed when it is beyond our control since the physician's office doesn't have them. And then the second part of this question is – again, in reference to the oxygen CERT audits, the request has different components. There are many elements to their request such as a copy of the initial evaluation, the re-evaluation, the initial and re-cert CMNs, the continued usage, et cetera. So let's say there are seven pieces of information being asked. If we provide five of seven, then chances are we will receive arecoupment. My question to that second part is, how – we are not receiving or should we be receiving something from CERT specifically telling us that we were denied because out of the seven elements being requested, we only responded to five and we are missing the two and those

two as follows – currently we simply assume that maybe we are getting denied because possibly we were not able to submit element A. Thank you very much.

James Herron: Hi Jerry, this is James Herron. How are you doing?

Jerry Francisco: I'm fine James.

James Herron: OK. Jerry just to go over this – to go over to your second point there, I do believe that when you do receive notification of a denial from the CERT contractor, it's going to be through an overpayment request from your MAC contractor, whether it be Jurisdiction C, A, B or D. That's really how you're going to receive your notification.

OK to your first question do understand you know where – that you know you have those concerns but as we have stated in the slides before, you know that is part of the CERT program is to determine whether or not medical records are there and as – I'm sorry – as – I'm sitting here drawing a blank right now, she's going to kill me –Amy Capece noted in Amy's piece she said you know that documentation is the key now going forward. So you really do need to document, document, document as Amy said. It can be you know a little time consuming and so forth when you're looking at something that's so – that you feel is old like that but I do you know remember that you know there are appeal rights to a CERT request and if you feel that something is done in error or you know you feel like you need to appeal that, then absolutely. You do have appeal rights.

Jerry Francisco: Thank you very much James.

James Herron: Thank you, Jerry.

Operator: Your next question comes from Teresa Canfield. Your line is now open.

Teresa Canfield: OK I'm with – Teresa Canfield, I'm with Pacific Pulmonary Services and I wanted to inquire specifically related to the physician medical records. As a provider, we do not have control over what a physician documents or doesn't document in their medical records. At the same time CERT is holding us

accountable for the lack of physician documentation. And to the point of medical record documentation and the length of retention, currently the length of retention is seven years.

So if the CERT is asking for medical record documentation, that would possibly go back before seven years or longer than seven years, how as a supplier can we control the fact that a physician no longer has that documentation and is it legally required to have it or retain because it's been greater than seven years. That's my first concern.

My second concern is that as a supplier we are educated by the LCDs and the Program Integrity Manual. We understand that the physician should document in the medical record, the patient's signs, symptoms and what would warrant the need for that piece of equipment. We understand that. At the same time, based on previous experience and in pulling and requesting those medical records from the physicians, we are finding that they may or may not document anything about ongoing medical need for oxygen, for enteral nutrition, for any type of equipment.

The patient can be walking into that physician's office with oxygen on and yet that physician does not document in that history or physical for that day that the patient entered the office with their own O2 on at 2 liters. What we're finding is that they document the initial assessment, they document at the time of the re-cert and that's pretty much it. The rest of the time that physician is documenting only about the patient's current ailment.

So my biggest question and the biggest concern in the provider community and we bill all four of the DME MACs is how can we be held accountable for what is documented in the physician's medical record when they have not been educated about our policies and procedures related to medical equipment as to what their progress note should include? Thank you.

James Herron: Thank you, Teresa. Of our presentation or of our presenters today, Amy, would you like to perhaps start with a response on this one because I know we have some additional information and jurisdiction as well?

Amy Capece: OK. Hi, this is Amy Capece. Just to start the response and it's probably not what you're going to want to hear. You're not going to like what I'm about to say but it truly is the responsibility again, of the supplier to have the information in your file and readily acceptable and available to support the medical need and the criteria for the equipment you are providing. So again, you know in part of the presentation we highly recommend that when you take on a patient, you make sure that you have the documentation and the information for the medical support of the equipment that you are providing to that beneficiary. And John, I don't know if you had something additional to add to that?

James Herron: Thank you Amy for that answer. And Teresa, this is James Herron, how are you doing? But I just really want to say that you know I've spoken to our counterparts and our peers with Part B and their MACs and the physicians are receiving education on proper documentation, working with DME MACs or working with durable medical equipment companies, in the sense that you are providing care for a beneficiary. So to ensure the beneficiary can get that equipment and maintain and keep that equipment, doctors do need to document, document, document and also physicians are receiving CERT audits as well. So you know it is ongoing and I do hope it gets better. So thank you Teresa, for the question.

Teresa Canfield: Thank you.

Operator: Your next question comes from Christina Bradley. Your line is now open.

George Rosie: Yes, this is George Rosie from Monroe Medical and we file through all of the DMERCs and I agree with the lady that was on there just a minute ago. I believe her name was Amy. It seems to me that the CERT program is placing all the responsibility on the providers to talk back to these physicians and to train these physicians and who are we to question what the physician is putting in the patient's chart? I just don't understand this. It seems like we're going around backwards on this whole thing that the physicians need training probably more than what we do. So I'm kind of confused on this. I know we've had five CERTs – what?

Female: Five – just regular audits.

George Rosie: Five audits. We furnish the information and they come back denied. So I'm kind of lost in this whole thing. We've had the accreditation team in our office. They said we're good to go. We've complied with all the Medicare standards with all the you know with all the getting bonded and everything and now we're coming out with this where you could look at any kind of filing and say, well they're missing this. Then just recoup the money or either throw it out. I mean we're already working on a very small budget. When you go to competitive bidding and you look at some of these companies, I mean we're already working within a 30 percent area and now you want us to document, document, document, which means hiring more and more people, it just seems like we're – it seems like a government program that is just destined for failure at least for the suppliers and I don't understand that. That's my question.

James Herron: Do we have any presenters who would like to feedback to the gentleman's question?

Jody Whitton: This is Jody from Noridian Jurisdiction D and I just want to kind of reiterate in a different way what Amy had mentioned. It's really important to do a thorough intake process and to know what documentation exists because you may need to have the documentation to protect yourself from liability because the beneficiary doesn't qualify for the piece of equipment. So documentation again, is so incredibly important in knowing that you have that information ahead of time. I know all jurisdictions have or at least our jurisdiction does have a documentation check list. There's documentation information indicated in the LCDs but working with your referral resources or sources and explaining to them – they get CERT audits as well. They get audited from, a you know Part A and Part B. So they're aware of the documentation requirements and like James had mentioned we are working with our local Part A and Part B carriers to enforce the documentation need in a DME community.

Amy Capece: Jody, thank you. This is – and this is Amy Capece again just to follow up a little bit on James' and Jody's statements. We are very much aware that there you know – there is a challenge with educating the physicians and just you

know where that lies and as we have reiterated and it stands as right now, it is the supplier's responsibility to obtain the documentation that's needed for the medical need of the equipment, to educate the suppliers or I'm sorry, the physician's office and you know the physician – the physician office staff as to what and why you need this information and why things have to be documented and again as James and I believe Jody mentioned, we as contractors are doing what we can to reach out more to the other jurisdictions and Part B contractors to try to at least network and disperse more information about the policies and things to the physician community and that is where we are right now with you know this type of issue. We do hear this quite often so you're not alone in thinking that. I'm sure you know that.

George Rosie: Right. This is still George with Monroe Medical. My issue is that we service patients and it's a one time – it's not oxygen, diabetic supplies or anything like that and I just don't understand how you know early in your presentation you listed the seven pieces of – seven elements there and then at the very end you said none of those are needed because of the physician's notes. So the importance of the physician's notes is paramount above everything else. So if the physician – I mean if we do everything right and then the physician turns around and doesn't document it in his records, then we get turned down and that just does not seem fair. Is it?

Jody Whitton: Again, this is Jody at Noridian and having that seven element order if you're referring to a PMD or any other type of detailed written order is important prior to submitting a claim or dispensing but it's got to be backed up with the medical records and you knowing and asking that question – as soon as that beneficiary walks into your place of business saying OK, who's your physician? You know. Make yourself a little checklist or a suggested intake form of your own to ask all of the pertinent questions that you know that the CERT audit or any other audit may come back to you and ask for. Medical records – what is documented in your medical records? Have a conversation with the physician. Act like a partner with that physician in making sure that the beneficiary is going to get the item that they need and get it paid for as it should be paid for by Medicare.

George Rosie: So what you're telling me is to have a conversation with the patient or with the physician?

Jody Whitton: Well, you're going to have to have a thorough intake process asking all the specific questions. Obviously you're going to need to have at the very minimum a dispensing order before you can dispense anything.

George Rosie: Absolutely and I – we've been checked with this accreditation team. We have those kinds of things but if you talk to most of the Medicare recipients out there, they can't even tell you what program they're under. So they have no clue on what's being documented in their records.

Jody Whitton: As soon as you get that information who the ordering physician is, give them a call. Find out what's in the record.

George Rosie: Well we do that. We do that. But I reckon what I'm really trying to say is that through these audits that we've been given, they come back denied. And we're doing the very best we can out here but they're being denied based on lack of information in the physician's records. So why are the suppliers being punished for what the physicians are writing in their records? Most of these physicians out there, which I'm sure you're well aware of are primary care physicians, urologists – these types of physicians see 50-60-70 patients a day. They're going to take the short cut. They're not thinking about us. But yet we're the ones that's having to pay the price for it.

Jody Whitton: I understand your frustration George.

George Rosie: I mean it really is frustrating to us because we try to do everything that is right and it just does not seem fair that we go through all this work and everything – I mean the patient's record – just to get one piece of equipment us, a patient's record is almost an inch thick, OK? That's a lot of paper and then for the CERT program to come back and go, well, the physician didn't document his records right so we're going to recoup the money from you. But the patient gets to keep the equipment. I don't understand that.

John Kelly: George. John Kelly. I'm moderating the call. I appreciate your questions and out of respect for others who are still waiting to ask some, I'd like to ask that

we move on to take those questions and perhaps you could reach back out to us and we can ...

George Rosie: Oh I will.

John Kelly: OK. Thank you.

Operator: Your next question comes from the line of Mary Murphy. Your line is now open.

Mary Murphy: My question's already been answered. Thank you.

Operator: Your next question comes from Kathleen Ferrigan. Your line is now open.

Kathleen Ferrigan: During the conference, they used the word 75 days in which to return the CERT request. Did I hear that correctly because on my CERTs they're saying 30 days and I even got one from region A for three days or maybe they dropped to zero.

Becky Harmon: Kathleen, hi this is Becky. Which jurisdiction do you normally bill through?

Kathleen Ferrigan: Probably normally D. But actually go – we go through all four.

Becky Harmon: OK. Kathleen, the 75 days is correct from the initial request. There are follow up letters that come out if they do not get the documentation within that 75 days and some of those you may be seeing some varied time frames but the normal process and the normal time frame for the CERT request is 75 days.

Kathleen Ferrigan: So the initial CERT request is 75 days?

Becky Harmon: That's correct.

Kathleen Ferrigan: Correct? Thank you very much.

Becky Harmon: Thank you Kathleen.

Operator: Your next question comes from Karen Corsen. Your line is now open.

Karen Corsen: OK. I think I have couple of questions but I'll try and get in the one that's most important to me at the time. It seems like we're receiving a lot of CERT audits for patients that are tested during sleep and my question is are the people that are reviewing these CERT audits understanding that a patient that has obstructive sleep apnea that requires oxygen while they are sleeping, are going to have perfectly normal O2 sats during the day when they're at the doctor's office? Because they only require oxygen when they're sleeping?

James Herron: Karen, hi. This is James Herron with Jurisdiction C. I apologize, can you restate that because you had – I guess are you saying that they're testing during sleep but they're – I'm not following you. Is it – you're saying that they – you're qualifying them while they're asleep and that the CERT contractors are looking at it from a standpoint of qualification while they're awake? I apologize. I didn't understand the question.

Karen Corsen: Right. Yes. No, these are patients that are tested during sleep because they have obstructive sleep apnea and require oxygen during sleep time only.

James Herron: OK.

Karen Corsen: When we send in our physician's notes which are the patients see their physicians during the day and they'll show a 90 percent O2 sat or they'll show you know O2 sats that are in normal range because they are being tested in a doctor's office during the day and we're being rejected because the patients have qualifying stats. They don't however qualify when they're sleeping. They're de-sating down into the 50s and the 60s and we're having difficulty getting that understood. Is that something that is commonly misunderstood?

James Herron: Well Karen, let me say this. The CERT review contractor here reviews the information. They are staffed with medically trained personnel so they do understand that. I guess the key there is making sure you submit to them the documentation that justifies the need for the oxygen based upon why the patient has the oxygen. So if there are no notes that would justify or there are no records from the physician that justify the need for the oxygen as it is billed to Medicare of as it is deemed if they need it, then that can be

problematic for you. So you do need to make sure that the documentation you have justifies the need for the oxygen as the patient is using it in the home.

Karen Corsen: I understand that and we are doing that. We are – we have sleep studies that qualify. We have continuing notes that indicate that the patient has obstructive sleep apnea, it's not a CPAP machine, is being treated with oxygen at night but they're holding, seem to be holding, us on these qualifying sats that happen during the day.

James Herron: OK. Thank you for that Karen and I just want to reiterate as I'd said before, if you do feel like there was a CERT – you have a denial that's done – you don't agree with it or you feel it was an error, you do have the appeal rights just as you would if any other denial – if it came from a DME MAC. So I would highly recommend that you know follow your appeal rights in the case.

Karen Corsen: We're certainly doing that. May I ask one more question?

James Herron: Yes, go ahead. Quickly please.

Karen Corsen: To constitute continued use – particularly like with a nebulizer and nebulizer medications, doesn't the ongoing annual prescriptions and continued shipment of nebulizer drugs indicate continued use?

James Herron: That's a good question Karen and yeah, I can certainly see where you're coming from that but again that does go back to medical records and medical documentation from a physician that would indicate the continued need for that item.

Karen Corsen: OK.

James Herron: OK? Thank you Karen.

Shana Olshan: John, this is Shana. May I just interrupt for one moment?

John Kelly: Absolutely Shana.

Shana Olshan: This is Shana Olshan at CMS. I just received some clarification by e-mail actually from our CERT experts about the prior question about the 75 days. I

just wanted to clarify the response. Our CERT expert just pointed out to me, the initial letter gives 30 days to return documentation. If the documentation is not received with 75 days, the claim is denied for no documentation. So the letter says 30 days but if you don't send it within 75, you'll be denied. So I hope that clarification helps.

John Kelly: Shana, thank you for the clarification. We appreciate that.

Operator: Your next question is from Laura Malina. Your line is now open.

Jim Fisher: Hi, my name is Jim Fisher from Region D.

Male: Hi Jim.

Jim Fisher: My question is who's responsible if the patient dies? The physician or the supplier?

Male: Did you say Region B or Region D, Jim? I'm sorry.

Jim Fisher: Region D.

Male: D? All right.

Jody Whitton: D as in dog?

Male: Yes. Jody, I think that one is yours.

Jim Fisher: So that would be mine, Jim. Jim, if a beneficiary dies, your Medicare will pay up until the date of death. As far as what is your specific question? Who's responsible for ...

Jim Fisher: My question is due to lack of documentation from the physician for the supplier to provide treatment, if the patient dies, who is responsible? Who's liable, the physician or the supplier?

Jody Whitton: Because of use of the equipment? I guess I'm just not getting the question. I'm sorry.

Jim Fisher: The physician wants the supplier to provide the – let's say oxygen. But there's lack of documentation and the supplier doesn't provide the equipment because they're not going to get paid. The patient dies. Who is responsible? Who is liable – the physician or the supplier?

Jody Whitton: Yes that would be kind of outside. That would be more of a legal issue that you want to ask. As far as your business practice decisions and who you dispense equipment to and the reason you dispense equipment is going to be something you determine. If you determine that the beneficiary doesn't meet the coverage criteria and you don't want to service that beneficiary, you can send them on to the next supplier or do whatever your business you know would want you to do.

Jim Fisher: Then what's that supplier supposed to do?

Jody Whitton: If you don't take a patient, what is that supplier supposed to do?

Jim Fisher: Well if the documentation isn't there, who's wrong?

Jody Whitton: Well the documentation needs to be there before you actually dispense the equipment or I would suggest the documentation is there before you dispense the equipment.

Jim Fisher: I feel like we're doing your job with the physicians.

Jody Whitton: Well you are – you as suppliers are expected to know the policies and the procedures and the rules and regs. There are very specific coverage criteria listed in each LCD or the policy article, knowing those and then doing your thorough intake process to make sure that that exists is very, very important.

Jim Fisher: I feel the physicians would rather hear this coming from you than from the supplier and I think they would be more compliant if this was coming from you directly to them in a meeting like this rather than the supplier.

Jody Whitton: Thank you, Jim but we actually do create physician letters. I know that we have some on our particular website under our coverage and MR tab where

our medical director, Dr. Whitton, had actually composed some to help assist you and use as a tool to get that medical justification.

Jim Fisher: Did we get a link to the power point slides?

Jody Whitton: They are on each contractor's website. On Noridian's it's under the training and events tab under presentations.

Jim Fisher: Thank you.

Jody Whitton: You're welcome.

John Kelly: Thank you. We have time for one more question please.

Operator: Your last question comes from Nicole Bailey. Your line is now open.

Nicole Bailey: Hi, this is Nicole from (inaudible) Home Care Region B in Hawaii. Is the question about I think one of the first callers the CERT people are asking for documentation from 11 years ago but you folks stated that you only require us to keep information like that on file for seven. From this point on, is CERT going to continue to ask for documents or documentation past seven years with that point being brought up?

Male: Thank you for your question. Shana, is this something that you might be able to contribute to?

Shana Olshan: Well on the safe note, I can't. It's the provider outreach. But it's something that we will definitely take back and look into. Because 11 years does seem long. So we will look into that and get answers out to all four DME MACs so they put on their website.

Male: Great thank you.

Nicole Bailey: And my last question – are electronic signatures from patients acceptable on delivery tickets?

Male: Jody, do you want to go ahead and take that one?

Jody Whitton: Seems like everything's switching more to electronic means. For the benefit – for proof of delivery electronic signature like when FedEx comes out and has them sign that electronic box?

Nicole Bailey: Yes.

Jody Whitton: Yes. That would be acceptable.

Nicole Bailey: That's all. Thank you.

John Kelly: All right thank you everybody. I know you have lots of questions and I wish we had several more hours to stay on the line to address them but we simply can't do that in this forum. I do want to remind you that we will be publishing an extensive list of all of the questions not only or answers, not only the questions you've asked during this call but also the over 150 questions that we received in advance of today's call. So be watching those will publish when we release the encore presentation in the next week or two to all DME MAC websites, if you have not already done so, please sign up for the listserv for your specific jurisdiction or contractor so that we can be sure to alert you when that information is published.

If you do have additional questions regarding the CERT program, I'd like to again remind you that all DME MAC contractor outreach and education units have extensive education, information and instruction available on their websites so please visit those websites for additional information and we will also provide you again responses to questions where I think you'll find additional answers to some of those areas that have or questions that have been raised today. Your DME MAC CERT Education Task Force would like to thank you for your feedback on today's education.

We would like to hear from you in terms of the – of how – if this education is beneficial to you. So in the next several days, you'll be receiving an e-mail from the CERT task force asking you to complete a survey to let us know what you thought about today's forum and make recommendations for additional education and information that would be of importance to you.

So we'd appreciate your response so we may continue to develop meaningful education for you on the CERT program. On behalf of the DME MAC CERT Education Task Force, we would like to thank CMS for their participation and support of this initiative and we would like to thank you for taking time out of your busy schedules today to join us. Thank you and have a great day.

Operator: This concludes today's conference call. You may now disconnect.

END