# Certifying Home Health Care

2015

# Today's Presenters

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# Acronyms

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# Today's Presentation

- Presentation is available on our website
  - Go to http://www.NGSMedicare.com
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# JK/J6 Territories

| Jurisdiction K | Jurisdiction 6 | |
|---|---|---|
| Maine | New York | California |
| New Hampshire | New Jersey | Alaska |
| Vermont | Michigan | Hawaii |
| Rhode Island | Wisconsin | Puerto Rico |
| Massachusetts | Minnesota | Mariana Islands |
| Connecticut | Idaho | American Samoa |
| | Nevada | Virgin Islands |
| | Washington | Guam |
| | Oregon | |

# Agenda

- Medicare HH benefit
- Regulatory changes 2015
- Beneficiary/patient eligibility
- Documenting eligibility
- Homebound status
- Need for skilled services
- Plan of care
- FTF encounters
- Certification
- Recertification
- Therapy
- Documentation collaboration
- CERT
- References & resources

# Medicare HH Benefit

- Services that the Medicare patient/beneficiary may receive at home include:
  - SN on an intermittent/part-time basis
  - HH aides on an intermittent/part-time basis
  - PT, OT, SLP, MSW
- These services have not changed for 2015

# Medicare HH Benefit

- For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, "intermittent" means:
  - Skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

# Medicare HH Benefit

- Medicare HH services include (per §1861(m) of the SS Act):
  - Routine & nonroutine medical supplies
    - Catheters & catheter care supplies, ostomy bags & ostomy care supplies
  - DME
    - Paid separately from the HH payment rates
  - An osteoporosis drug - injectable calcitonin
    - As per §1861(kk)… reimbursed on a reasonable cost basis & the patient must meet certain criteria

# Excluded from the Medicare HH Benefit

- Services that are excluded from the Medicare HH benefit include:
  - Drugs and biologicals
    - Covered under Part B and Part D
  - Transportation
  - Housekeeping services
  - Services covered under ESRD program
    - Example: wound care for an active shunt site

# 2015 Change Request 9119 Regulatory Changes

- CMS has eliminated the narrative requirement (regarding the patients' homebound status & need for skilled services)
- For medical review purposes, CMS requires documentation from the certifying physician's medical records (referring physician) and/or the acute/post-acute care facility's medical records (community physician) if the patient was directly admitted to HH, to be used as the basis for certification of patient eligibility

# 2015 Change Request 9119 Regulatory Changes

- If HHA claim is denied, corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered HH services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered HH services
- CMS clarified that a FTF encounter is required for certifications, rather than initial episodes; and that a certification (versus a recertification) is generally considered to be any time a new start of care assessment is completed to initiate care

# Patient/Beneficiary Eligibility

- Medicare Part A and/or Part B & §1814(a)(2)(C) and §1835(a)(2)(A) state that when the physician refers a patient to HH, the patient must:
  - Be confined to the home
  - Need skilled services
  - Be under the care of a physician
  - Receive services under POC established and reviewed by a physician
  - Have had a FTF encounter for their current diagnosis with a physician or allowed NPP
- Reminder: All home care services must be furnished by or under arrangements made by a Medicare-participating HHA.

# Documenting Eligibility

- Documentation in certifying (referring) physician's medical records and/or acute/post-acute care facility's medical records (if patient was directly admitted to HH) will be used as basis upon which patient eligibility for Medicare HH benefit will be determined
  - Documentation from certifying (referring) physician's medical records and/or acute/post-acute care facility's medical records (if patient was directly admitted to home health) used to support certification of HH eligibility must be provided, upon request, to the HHA, review entities, and/or CMS

# Documenting Eligibility

- The referring physician must identify the name of the community physician who will be monitoring the patient's HH services.

# Documenting Eligibility

- Physicians: HCPCS – G0180 (Certification) & G0179 (Recertification) of "patient eligibility for Medicare-covered home health services under a HH POC (patient not present), including contacts with the HHA and review of reports of patient status required by physicians to affirm the initial implementation of POC that meets patients' needs, per certification period"
  - If there are no covered services, these codes should not be billed or paid. As such, these claims will not be covered if HHA claim itself was non-covered due to certification/recertification ineligibility or because there was insufficient documentation to support that the patient was eligible

# Documenting Eligibility

- HHA and physician who will be following patient's care in community should receive the following documentation from referring physician or facility in a timely fashion, in an effort to provide timely and appropriate initial start of care procedures:
  - Referral/Order for HH Services
  - Basic initial POC
  - FTF encounter documentation
  - Documentation supporting the need for skilled service
  - Documentation supporting the homebound status
  - Certification &/or recertification statement

# Documenting Eligibility

- It is the sole responsibility of the certifying (referring) & community physicians to record all pertinent HH information in the medical record and share the documentation with the HHA
- HHA documentation should also be shared, as it compliments & supports documentation in referring, certifying & community physicians records

# Documenting Eligibility

- HHA must be able to provide, upon request, supporting documentation that substantiates eligibility for Medicare HH benefit to review entities and/or CMS
  - If documentation used as basis for certification of eligibility is not sufficient to demonstrate that patient is or was eligible to receive services under the Medicare HH benefit, payment will not be rendered for HH services provided.

# Homebound Status

- Per §1814(a) and §1835(a) of the Act, an individual shall be considered "confined to the home" (homebound) if criteria on next slide are met

# Homebound Status

| Criteria One<br>One Standard Must Be Met |
| --- |
| Because of Illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person to leave their place of residence. |
| **OR** |
| Have a condition such that leaving his or her is medically contraindicated. |

| Criteria Two<br>Both Standards Must Be Met |
| --- |
| There must exist a normal inability to leave home. |
| **AND** |
| Leaving home must require a considerable and taxing effort. |

# Homebound Status

- The patient may be considered "confined to the home" (homebound) if absences from the home are:
  - Infrequent and relatively short in duration
  - For medical appointments/treatments
  - For religious services
  - To attend adult daycare programs
  - For other unique or infrequent events
    - funeral, graduation, hair care

# Homebound Status

- Documenting homebound status:
  - Include information about the injury/illness & the type of support and/or supportive device/assistance required for illness/injury to assist the patient in leaving home
  - Explain in detail how the patient's current condition makes leaving home medically contraindicated
  - Clarify exactly what about the illness qualifies the patient as homebound
- Reminder: Declaring any portion of this regulation as a blanket statement copied from the CMS manual is vague. An explanation is required that describes the patients normal inability to leave home and exactly what effects are causing the considerable and taxing effort to leave home

# Need for Skilled Services

- Documenting the need for any/all skilled services requested (including NSG, PT/OT/SLP, SW):
  - Distinguish exactly what services are going to be provided by the skilled professional in the patients home
  - Explain why a skilled professional is required to provide the HH care services requested
  - Disclose clinical information (beyond a list of recent diagnoses, injury, or procedure) that is individual and specific to the patient
  - Clarify why the findings from the FTF encounter with the patient support the medical necessity of the services being requested

# Plan of Care

- It is expected that in most instances, physician who certifies patient's eligibility for Medicare HH services, in accordance with §30.5, will be same physician who establishes and signs POC; Therefore…

# Plan of Care

- If patient is starting HH services directly after discharge from an acute/post-acute care setting where referring physician, with privileges, that cared for patient in that setting is certifying patient's eligibility for HH benefit, but will not be following patient after discharge, then certifying (referring) physician **must identify the community physician who will be following the patient after discharge.**

# Plan of Care

- Reminder: One eligibility criterion that must be met for a patient to be considered eligible for HH benefit is that patient must be under the care of a physician. Otherwise, certification is not valid. CMS has outlined expectation of the content of the POC in Chapter 7 Section 30.2.

# Plan of Care

- Per §1814(a)(2)(C) and §1835(a)(2)(A) of the Act, patient must receive HH services under POC established and periodically reviewed by a physician
- When a beneficiary/patient is referred to HH services, it is beneficial to have an initial basic POC prior to their SOC. HHA will further develop the POC with assistance of community physician following patient's care
- Form 485 is not a current or endorsed CMS document
- Currently, there are no mandatory CMS forms for the POC

# Plan of Care

- FTF encounter and POC can be certified in one certification statement
- Certifying physician must be enrolled in Medicare program and be a doctor of medicine, osteopathy, or podiatric medicine
- Certifying physician cannot have financial relationship with HHA unless it meets one of exceptions in 42CFR411.355-42CFR411.357
- If a NPP provides the FTF encounter, a certifying physician must review & countersign the document
  - Allowed NPPs include: PA, CNS, NP, and CNM

# Plan of Care

- Reminder: Because residents do not have privileges, if a resident is performing the FTF encounter, he/she must inform certifying physician of encounter through supervising teaching physician who must review & countersign

# FTF Encounters

- FTF encounter is part of certification of patient eligibility
- FTF encounter with patient must be performed by certifying (referring) physician himself or herself, a physician that cared for patient in acute or post-acute care facility (with privileges who cared for patient in an acute or post- acute care facility from which patient was directly admitted to HH) or an allowed NPP
- Currently, there are no mandatory forms for FTF encounter

# FTF Encounters

- There must be a documented FTF encounter in the patient's medical records which collaborates with all of the other medical entities (Referring Physician, HHA & Community Physician) involved in the HH services

# FTF Encounter 2015 Changes

- 2014
  - FTF Encounter
    - Narrative mandatory regarding:
      - Need for skilled services, and
      - Homebound status
- 2015
  - FTF Encounter
    - Narrative required when:
      - Skilled oversight of unskilled care is ordered

# FTF Encounters Timing Requirement

- Timing requirements for "in-person" encounter:
  - Up to 90 days prior to the SOC
    - If visit was for same diagnosis/condition that now requires HH services
  - Within 30 days after the SOC
    - For diagnosis/condition that requires HH services
- Exception to timing requirements
  - If patient dies shortly after admission to HH
    - There must be a documented good faith effort to facilitate/coordinate the FTF encounter, and
    - All other certification requirements must have been met

# FTF Encounters Documentation Requirements

- FTF should contain:
  - Title (as the FTF encounter)
  - Patient's full name
  - Date of the actual FTF encounter
  - Narrative information required only when skilled oversight of unskilled care is ordered by the physician
- Certification statement may be on this FTF document, it may be on the POC, or it may be a separate document, such as a discharge summary

# FTF Encounters Reminders

- FTF encounter is component of the certification
- Along with the other eligibility criteria, the physician certifies that the patient was seen and had a FTF encounter for the current diagnosis
- Certification statement may be on FTF encounter form, POC or separate form of its own
- Skilled oversight narrative must be above the certification statement
- Electronic signatures are acceptable

# Certification

- Physician certifies/recertifies that patient has met all five of the eligibility criteria when referring to HH:
  - Confined to his/her home
  - Requires intermittent skilled services
    - Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification
  - POC has been established and is periodically reviewed by a physician
  - Services that are furnished under the care of a physician
  - Individual had a FTF encounter

# Certification

- Certification of FTF and POC is a requirement for eligibility of services ordered and delivered via HH; Therefore,
  - **Referring physician must identify physician in community that will be monitoring patient's home care. **
  - Payment cannot be made for covered HH services that a HHA provides without physician certification that is obtained at time POC is established or as soon thereafter as possible
  - Certification (versus recertification) is considered to be anytime that a SOC OASIS is completed
  - Certification must be complete prior to when HHA bills. It is not acceptable for HHA to wait until end of 60 day episode to obtain certification/recertification
  - Rubber Stamp signatures are not acceptable
  - Certification by physician must be retained by HHA

# Certification

- HHA must enter date that identifies period covered by physician's POC
- "FROM" date for initial certification must match "SOC" date
- "THROUGH" date can be up to, but never exceed a total of 60 days
  - This includes SOC date plus 59 days

# Certification

- Example:
  - Initial certification "From" date 10012000
  - Initial certification “Through" date 11292000
  - Recertification "From" date 11302000
  - Recertification “Through" date 01282001

# Example Certification Statement

- I certify/recertify that the above stated patient is homebound and that upon completion of the/this FTF encounter, has a need/continued need for intermittent skilled nursing, physical therapy and/or speech or occupational therapy services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.
- John Smith, MD
- 1/1/2015

# Sample Documentation Process from Physician Office

- PCP or Specialist sees the patient in their office/clinic
- Completes an order/referral and certifies an initial POC & FTF encounter
- Forwards order/referral, initial POC & FTF documentation immediately to the HHA
- HH Agency carries out  SOC & assists in further development of the POC
- Monitors the patient's care, updates & recertifies the POC in collaboration with the HHA as required
- The physician and HHA maintain up-to-date home care documentation in the patients medical records

# Sample Documentation Process from Acute or Post Acute Facility

- Physician or NPP discharges the patient from their acute or post acute facility (Hospital/SNF/Inpatient Rehabilitation Center/Surgery Center), identifying the physician who will be monitoring the patients care in the community
- Completes an order/referral and certifies an initial discharge POC & FTF encounter
- Maintains records and forwards order/referral, initial POC & FTF documentation immediately to HHA & office of physician in the community that will be following the home care services – ensuring both entities are aware of services ordered, documenting follow-through
- HHA carries out SOC & assists in further development of the POC
- Community physician monitors patient's care and updates & recertifies the POC in collaboration with the HHA as required
- Community physician & HHA maintain up-to-date home care documentation in the patient's office medical record

# Recertification

- Recertification is required at least every 60 days when there is a need for continuous HH care after an initial 60-day episode unless there is a:
  - Patient-elected transfer
  - Discharge with goals met with no expectation of a return to HH care for the current diagnosis
    - These situations would trigger a new certification, rather than a recertification
- Medicare does not limit the number of continuous episode re-certifications for patients who continue to be eligible for the HH benefit.

# Recertification

- Recertification must :
  - Be obtained at the time the plan of care is reviewed since the same interval (at least once every 60 days) is required for the review of the plan.
  - **Include an estimate of how much longer the skilled services will be required** (certify the same eligibility criteria stated in the certification, including that a FTF was completed for the initial SOC preceding this recertification).
  - Be signed & dated  by the physician who reviews the plan of care.

# Recertification

- The form of the recertification and the manner of obtaining timely recertifications are up to the individual agency.
- The certification or recertification visit can be done during a prior episode.
- The Medicare Conditions of Participation (COPs), at 42 CFR 484.55(d)(1), require that the recertification assessment be done during the last 5 days of the previous episode (days 56-60).

# Recertification

- Services that are provided in the subsequent 60-day episode certification period are considered provided under the POC of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record.
- Services that are provided after the expiration of the POC, but before the acquisition of an oral order or a signed POC are not considered provided under a POC.

# Recertification: Overlapping Episodes

- If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there is no recertification assessment of the patient, then the new certification begins with the new start of care date after inpatient discharge.

# Recertification: Overlapping Episodes

- If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay on day 61, if the home health resource group (HHRG) remains the same then the second episode of care would be considered continuous and thus be considered a recertification.
  - However, if the home health reimbursement grouper (HHRG) is different, this would result in a new SOC OASIS and thus be considered a new certification and begins with the new start of care date after inpatient discharge.

# Recertification: Overlapping Episodes

- If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent episode and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay after day 61 (after the first day of the next episode of care), then a new certification begins with the new SOC date after inpatient discharge.

# Recertification: Verbal Orders

- Services that are provided in the subsequent 60-day episode certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record.
  - However, services that are provided after the expiration of the POC, but before the acquisition of an oral order or a signed POC are not considered provided under a plan of care.

# Therapy

- For multi-discipline therapy cases, a qualified therapist from each of the disciplines must functionally reassess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.
- CMS has eliminated the 13th and 19th visit therapy reassessment requirements.
- For episodes beginning on or after January 1, 2015; at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient.

# Collaboration of Supporting Documentation

- Certifying (referring) physicians and acute/post-acute care facilities must provide the medical record documentation that justifies the referral and supports the certification of patient eligibility
  - Certifying physicians who show patterns of noncompliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.

# Collaboration of Supporting Documentation

- Documentation in the certifying physician's medical records (and/or the acute/post-acute care facility's medical records) shall be used as the basis for certification of HH eligibility
  - If this documentation is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare HH benefit, payment will not be rendered for HH services provided

# Collaboration of Supporting Documentation

- Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.
  - Information from the HHA can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
  - The certifying physician must review and sign any documentation incorporated into the patient's medical record that is used to support the certification.

# Collaboration of Supporting Documentation

- Certifying (referring) physician's and/or the acute/post-acute care facility's medical record for the patient must contain:
  - Information that justifies the eligibility for Medicare HH services ordered. This includes documentation that substantiates the patient's:
    - Need for the skilled services
    - Homebound status
  - Actual clinical note for the FTF encounter visit that demonstrates that the encounter:
    - Occurred within the required timeframe
    - Was related to the primary reason the patient requires HH services
    - Was performed by an allowed provider type.

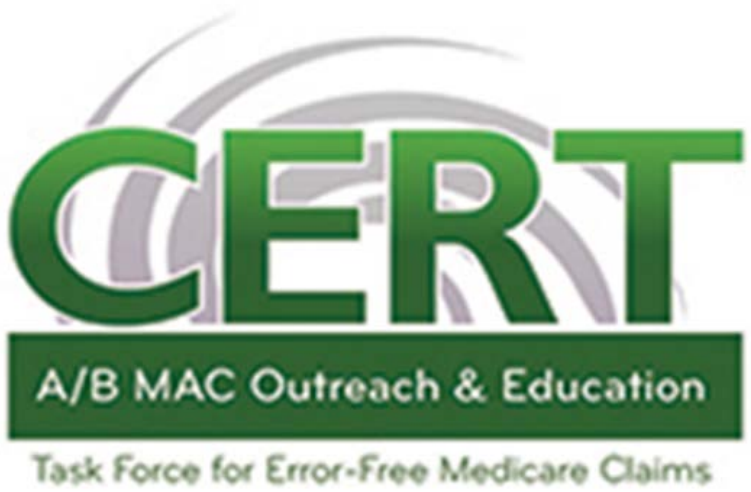
# Collaboration of Supporting Documentation

- Reminder: Information to support patient eligibility may be found in clinical progress notes, discharge summaries, etc.

# Questions

- Please type in any questions you may have to the question box at this time and they will be addressed momentarily…

# CERT A/B MAC Outreach & Education Task Force



# CERT A/B MAC Outreach & Education Task Force

- A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program
- Shared goal of reducing the national improper payment rate as measured by the CERT program
- Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions
- **Disclaimer:** The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

# Participating Contractors

- Cahaba Government Benefit Administrators, LLC/J10
- CGS Administrators, LLC/J15
- First Coast Service Options, Inc./JN
- National Government Services, Inc./J6 and JK
- Noridian Healthcare Solutions, LLC/JE and JF
- Novitas Solutions, Inc./JH and JL
- Palmetto GBA/J11
- Wisconsin Physicians Service Insurance Corporation/J5 and J8

# CERT A/B MAC Outreach & Education Task Force

- The CERT Task Force educates on common billing errors and contributes educational Fast Facts to the CMS website
  - CMS MLN Provider Compliance Fast Facts web page
    - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ ProviderCompliance.html
  - In addition, the CERT Task Force section on the NGSMedicare.com website provides a link to the CMS MLN Provider Compliance Fast Facts

# CERT A/B MAC Outreach & Education Task Force

- CERT Task Force Web Page
  - Go to our website, http://www.NGSMedicare.com; in the **About Me** drop down box, select your provider type and applicable state, click on **Next**, **accept** the **Attestation**. Choose the **Medical Policy & Review** tab, then choose **CERT**, the **CERT Task Force** link is located to the right of the web page.
- Task Force Scenarios
  - Complying with medical record documentation requirements
  - Documenting therapy and rehabilitation services
  - Look for new articles added to this page and provided in your Email Updates

# CERT A/B MAC Outreach & Education Task Force

- CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force
  - CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force
    - http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html

# References & Resources

# Today's Presentation

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  - Under the Register button for this event, you will see the Presentation link
- Materials from prior webinars are available
  - Click the Education tab, then Past Events

# 2015 Federal Register Reference

- Federal Register Vol. 79, No. 215
- Released: Thursday, November 6, 2014
- Page 66117
  - http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf

# CMS Medicare Learning Network Article SE 9119

- "Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services"
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf
  - In accordance with its references to the CMS IOM Publication 100-01 and 100-02.

# CMS References & Resources

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual* Chapter 6
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* Chapter 7
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual* Chapter 10
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf

# CMS References & Resources

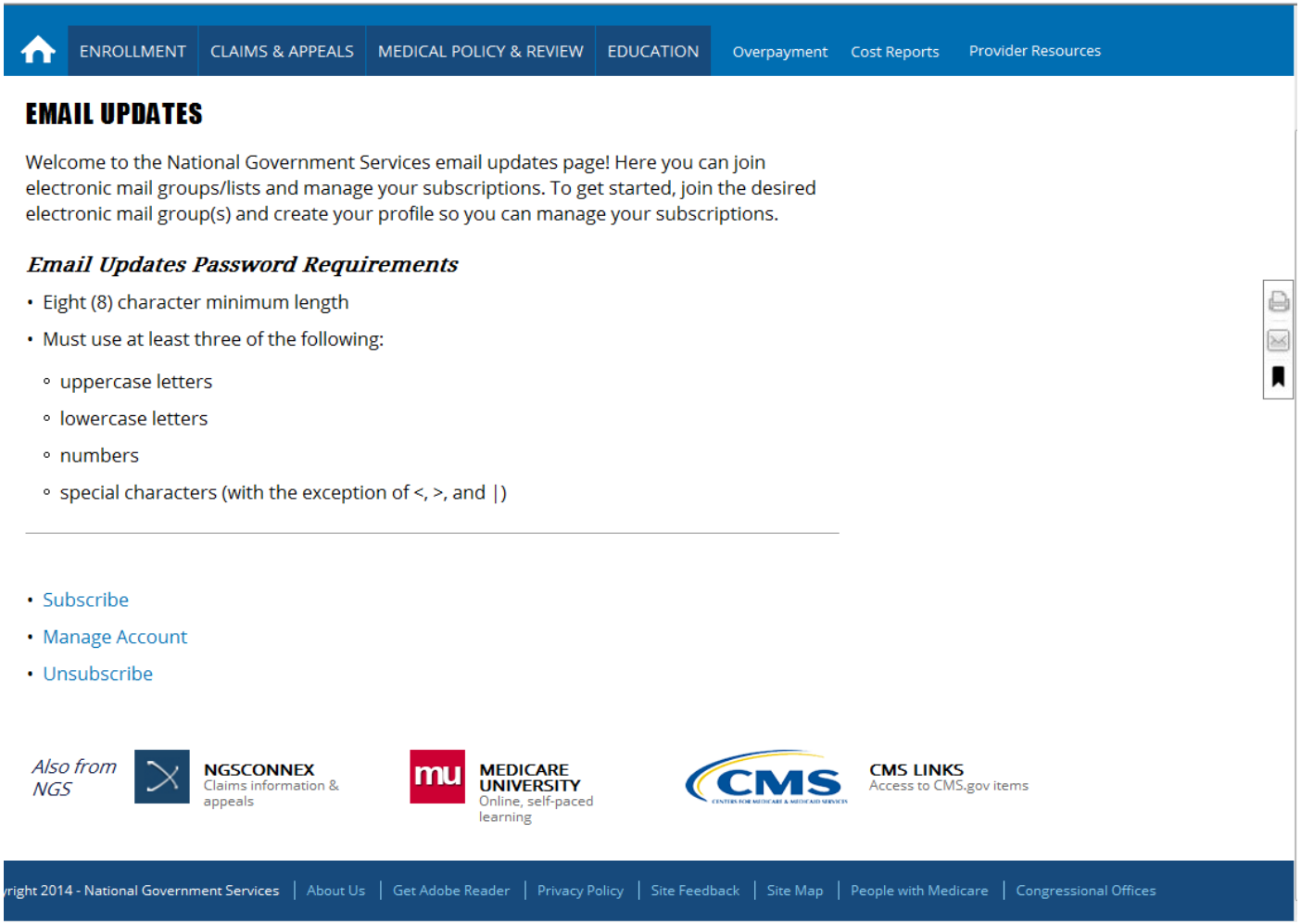
- HH PPS Web Page
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html
- Medicare HH Agency Web Site
  - http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- Medicare Learning Network® Publication titled "HH Prospective Payment System"
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HomeHlthProsPaymt.pdf

# Upcoming Educational Events

| Date | Event |
|---|---|
| June through December Bi-Monthly | Certifying HH 2015 Webinars (HHA's) |
| June through December Bi-Monthly | Ordering HH Services for a Medicare Beneficiary/Patient 2015 (Referring Physicians) |
| June 3 | J6 - HH&H Lets Chat Webinars |
| September/October | J6 - Fall Road Show |

# Email Updates

- Subscribe to receive the latest Medicare information.



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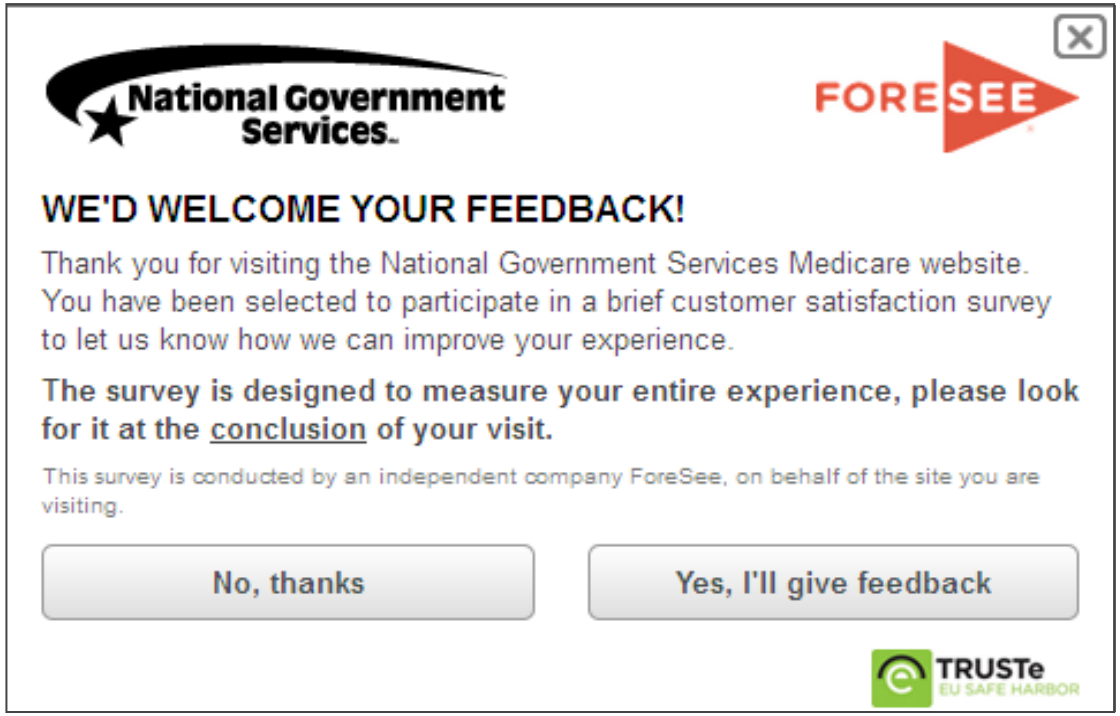

# Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Website
  - http://www.MedicareUniversity.com

# Medicare University Self-Reporting Instructions

- Log on to National Government Services' Medicare University
  - http://www.MedicareUniversity.com
    - Topic = **Certifying Home Health Care**
    - Medicare University Credits (MUCs) = **1**
    - Catalog Number = To be provided
    - Course Code = To be provided
  - Visit our website for step-by-step self-reporting instructions.
    - Click on the **Education** tab, then the **Medicare University Course List** tab, click on the **Get Credit** link. This will open the **Get Credit for Completed Courses** web page.

# Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received.
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs.

# Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?