Ordering Home Health Services for a Medicare Beneficiary

2015

Today's Presenters

- Shelly Bernardini RN, CPHM
  - Lead Medicare Home Health Clinical Consultant

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website at http://www.cms.gov.

No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Acronyms

- Acronyms used in this presentation can be viewed on the **NGSMedicare.com** website. On the **Welcome** page, click on **Provider Resources > Acronyms**.

Today's Presentation

- Presentation is available on our website
  - Go to http://www.NGSMedicare.com
  - In the **About Me** drop down box, select your provider type and applicable state, click on **Next**, **accept** the **Attestation**. On the Welcome page, click the **Education** tab, then **Webinars, Teleconferences & Events**
  - 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**

JK/J6 Territories

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

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)

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 (referring) physician's medical records and/or the acute/post-acute care facility's medical records (community physician) if the patient was directly admitted to home health, to be used as the basis for certification of patient eligibility

2015 Change Request 9119 Regulatory Changes

- If a 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 correspond ding 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

2015 Change Request 9189 Regulatory Changes

- Highlights the eligibility criteria that are to be identified at the time of certification
- Details the information that is to be reviewed by the contractor to uphold patient eligibility & medical necessity
- Outlines the certification and recertification documentation requirements

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 the 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 the certifying referring physician's medical records and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to HH) **used to support the certification of home health eligibility** must be provided, upon request, to the HHA, review entities, and/or CMS.

Documenting Eligibility

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

Documenting Eligibility

- Physicians: HCPCS G0180 (Certification) & G0179 (Recertification) of "patient eligibility for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with the HHA and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care 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 the HHA claim itself was noncovered 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 certifying 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 identifying the physician that will be monitoring the POC with the home health agency
  - Discharge Plan or Basic Initial POC
  - FTF Encounter Documentation – Discharge Summary or Interoffice Progress note documenting the 1:1 physician visit
  - Documentation Supporting the Need for Skilled Service & Homebound Status
  - Certification &/or Recertification Statement encompassing the F2F & POC

Documenting Eligibility

- It is the sole responsibility of the certifying (referring) & community physicians to record all pertinent HH information in medical record and share 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 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 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 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

- Declaring any portion of the regulation as a blanket statement copied from the CMS manual is vague ("It's a taxing effort for the patient to leave home"). Documentation must:
  - 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 the distinct difference in the patients normal ability versus their normal inability
  - Describe exactly what effects are causing the considerable and taxing effort for this patients when leaving home

Homebound Status

- If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.
  - For medical appointments/treatments
  - For religious services
  - To attend adult daycare centers for medical care
  - For other unique or infrequent events
    - Funeral, graduation, hair care

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

- The POC is part of the certification of eligibility
- As per CR 9189:
  - The referring/certifying physician's initial order for home health services initiates the establishment of a POC (for example: discharge plan) as part of the certification of patient eligibility
  - The physician's initial order must specify the medical treatments to be furnished and does not eliminate the need for the POC

Plan of Care

- It is expected that in most instances, the physician who certifies the patient's eligibility for Medicare home health services… will be the same physician who establishes and signs the POC…
- The HHA staff will further develop and evolve the POC with the community physician

Plan of Care

- If the patient is starting home health services directly after discharge from an acute/post-acute care setting where the referring physician, with privileges, that cared for the patient in that setting is certifying the patient's eligibility for the home health benefit, but will not be following the patient after discharge, then the certifying referring physician **must identify the community physician who will be following the patient after discharge.**
  - Reminder: One of the eligibility criteria that must be met for a patient to be considered eligible for the home health benefit is that the patient must be under the care of a physician. Otherwise, the certification is not valid.

Plan of Care

- CMS Form 485 is no longer an up-to-date or CMS endorsed document
- IMPROPER CERTIFICATION STATEMENT on CMS Form 485:
  - I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
- Currently, there are no mandatory CMS forms for the POC

Plan of Care

- Certifying physician must be enrolled in the Medicare Program and be a Doctor of Medicine, a Doctor of Osteopathy; or a Doctor of Podiatric Medicine
- Certifying physician cannot have financial relationship with HHA unless it meets one of exceptions in 42CFR411.355-42CFR411.357
- If a NPP or a resident provides the FTF encounter, a certifying physician must review & countersign the document. Allowed NPPs include: PA, CNS, NP, and CNM

FTF Encounters

- FTF encounter is part of the certification of patient eligibility
- All HHA's & community physicians require a copy of the documentation to support that it occurred
- A FTF encounter with the patient must be performed by the certifying referring physician himself or herself, a physician that cared for the patient in the acute or post-acute care facility or an allowed NPP
- Currently, there are no mandatory forms for the FTF encounter

FTF Encounters

- All 5 eligibility criteria and proof that a F2F encounter occurred will be concluded via review of the referring/certifying physicians medical record
- The F2F encounter and the POC require certification
- Reminder: The F2F encounter is not captured in the certification statement on the CMS Form 485

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 Documentation Requirements

- FTF encounter document should contain:
  - 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
- The certification statement regarding the 5 eligibility criteria, including the F2F encounter) may be located on the FTF encounter document, the discharge plan, a POC, or it may be found on separate document, such as a progress note, discharge summary.
- Electronic signatures are acceptable.
- When there is a F2F encounter narrative requirement regarding skilled oversight, it must be located above the certification statement.

Certification

- Certification of the F2F and POC is a requirement of HH eligibility criteria and should be retained by the HHA
- The physician certifies/recertifies that the patient has met all 5 of the eligibility criteria when referring to Home Health:
  - Be confined to the home
  - Need skilled services
    - Skilled oversight of unskilled services
  - Be under the care of a physician
  - Receive services under POC established and reviewed by a physician
  - Have 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

- Per CR 9189:
  - The certifying physician must also document the date of the face-to-face encounter as part of the certification
  - There is no specific form or format for the certification, as long as the five certification requirements are met

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

- The physician certifies that all of the eligibility criteria have been met.
  - Certification must be complete prior to when the HHA bills
  - Payment cannot be made for covered home health services that a HHA provides without physician certification that is obtained at the time a POC of discharge plan is established (or as soon thereafter)
  - A certification (versus recertification) is considered to be anytime that a Start of Care (SOC) OASIS is completed
  - Rubber stamp signatures are not acceptable
  - Certification by the physician must be retained by the HHA

CR 9189 Certification

- Home health agencies require as much documentation from the certifying physicians medical records and/or the acute/post-acute care facility's medical records as necessary to assure that the patient eligibility criteria have been met and must be able to provide it to CMS and its review entities upon request.

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

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 the order/referral, certified initial POC & FTF documentation immediately to the HHA
- HH Agency carries out SOC & assists in further development of the POC
- The physician 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

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 in the documentation the physician who will be monitoring the patients care in the community
- Completes an order/referral and certifies a discharge plan & FTF encounter
- Forwards order/referral, certified POC & FTF documentation immediately to HHA & office of physician in the community that agreed to follow the home care services
- HHA carries out SOC & assists in further development of the POC with the community physician
- 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

- Per CR 9189 - For all medical necessity reviews, the Medicare review contractors shall:
  - Determine whether the supporting documentation addresses each of the 5 certification criteria.
  - Review the certification documentation for any episode initiated with the completion of a start of care OASIS assessment.
    - This means that if the subject claim is for a subsequent episode of care, the home health agency must submit all certification documentation as well as recertification documentation.

CR 9189: Recertification of Skilled Oversight

- If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, a physician must document a brief narrative describing the clinical justification of this need.
- If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

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 recertification's are up to the individual home health agency and the physician monitoring the patients care in the community.
- The 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).

Collaboration of Supporting Documentation

- As per CR 9189:
  - The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services.
  - It is the patient's medical record held by the referring certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for home health services.

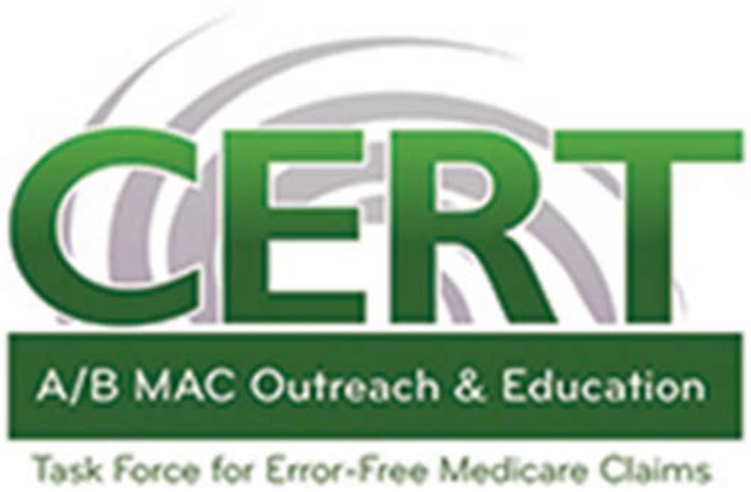
Collaboration of Supporting Documentation

- 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 referring physician's and/or the community physician'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. If to be used for verification of the eligibility criteria, this documentation must be dated prior to the certification.

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

- Presentation is available on our website
  - Go to http://www.NGSMedicare.com
  - In the About Me drop down box, select your provider type and applicable state, click on Next, accept the Attestation. On the Welcome page, click the Education tab, then Webinars, Teleconferences & Events
  - 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 Publications 100-01 and 100-02

Change Request 9189

- The purpose of this Change Request (CR) is to manualize policies in the calendar year 2015 Home Health Prospective Payment System Final Rule published on November 6, 2014, in which the CMS finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services.
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R602PI.pdf

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

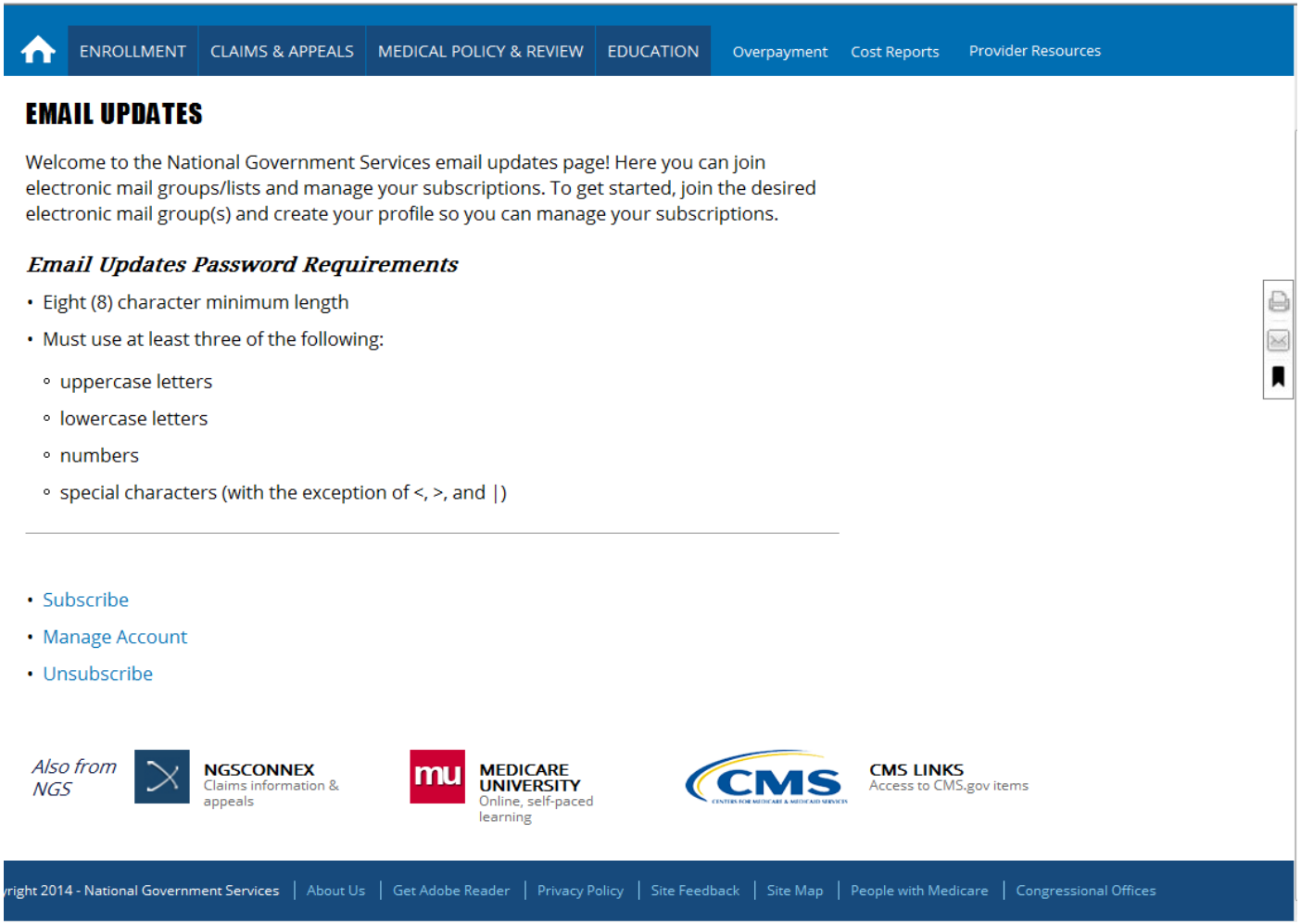
- HH PPS Web Page
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html
- Medicare HH Agency Web Site
  - http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- Medicare Learning Network® Publication titled “HH Prospective Payment System”
  - 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)
October/November	J6 - Fall Road Show

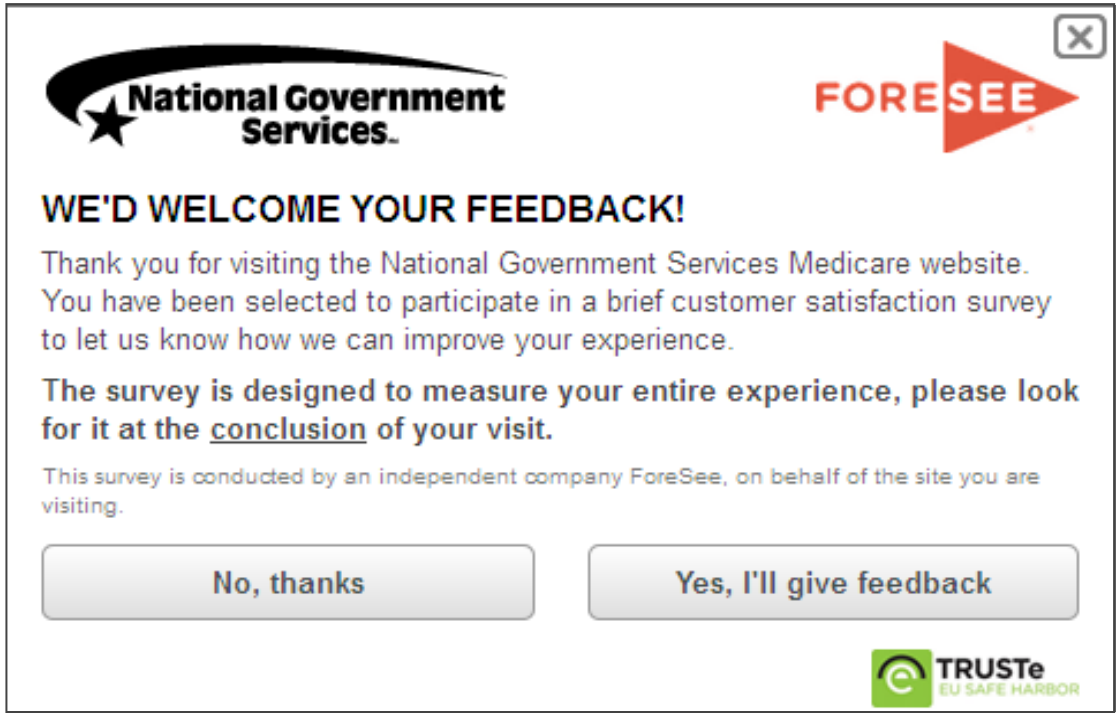
Email Updates

- Subscribe to receive the latest Medicare information.



Website Survey

- This is your chance to have your voice heard—Say “yes” when you see this pop-up so National Government Services can make your job easier!



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 = **Ordering Home Health Services for a Medicare Beneficiary/Patient**
    - 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?