Home Health Therapy Documentation and Billing

2015

Today's Presenters

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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**

Objective

- Provide an explanation of the regulations behind HH PPS and how documentation affects billing for therapy services

Agenda

- HH Medicare benefit & eligibility
- Certification of HH devices
- Therapy documentation
  - Assessment
  - Reassessment
  - Multiple disciplines
- HH PPS
  - Billing
  - Reimbursement
- Therapy billing under HH POC
- References and resources
- Questions

Medicare HH Benefit & Eligibility Criteria

- To qualify for Medicare HH benefit, Medicare beneficiary must meet following eligibility requirements:
  - Be confined to the home
  - Under the care of a physician
    - Must be identified at the time of referral to HH care
  - Receiving services under a POC established and periodically reviewed by a physician
  - Be in need of skilled nursing care on an ***intermittent*** basis or PT or SLP
    - Or have a continuing need for OT
  - Have had a documented F2F Encounter

Patient/Beneficiary Eligibility Proper Documentation Process

- Referring certifying physician → HHA & community physician
  - Referral/order for HH services
  - POC (discharge plan from referring physician)
  - FTF encounter documentation
  - Documentation supporting the need for skilled service
  - Documentation supporting the homebound status
  - Certification and/or recertification statement

Patient/Beneficiary Eligibility Proper Documentation Process

- 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

Patient/Beneficiary Eligibility Collaboration of Documentation

- HH Agency
  - Referring physician
  - Therapists
  - DME providers, pharmacies
  - Community physician

Certification Requirements

- Certification should be complete when POC is established
- Certification should be complete prior to submission of Medicare claim for reimbursement
  - It is unacceptable to wait until the end of a 60-day episode to obtain certification
- *Recertifications – estimate of how much longer the skilled services will be required

Certification Requirements Supporting Documentation

- Certifying (referring) physician's medical records (and/or acute/post-acute care facility's medical records) shall be used as the basis for certification of HH eligibility
  - If this documentation does not support patient eligibility payment will not be rendered for HH services provided

Certification Requirements Supporting Documentation

- Certifying physicians and acute/post-acute care facilities must provide medical record documentation that supports certification of patient eligibility
  - Noncompliance may cause increased reviews, such as provider-specific probe reviews

Coverage for Therapy Under HH PPS

- 40.2 - Skilled Therapy Services
  - Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14
    - To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury
    - Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care

Reasonable & Necessary Therapy Services

- 40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy
  - Skilled therapy services must be of such inherent complexity that they can only be safely and effectively performed by or under the general supervision of a skilled therapist
  - To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury

Reasonable & Necessary Therapy Services

- The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety
- Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program

Reasonable & Necessary Therapy Services

- Services that are ordinarily considered unskilled may be considered skilled if there is clear documentation that medical complications require skilled personnel for the services ordered
  - Can the services be provided by unskilled personnel?
    - Diagnoses and/or prognoses should not be utilized as the sole determining factor regarding whether services are skilled or not skilled
    - The importance or frequency of a service to a patient should not be utilized as the sole determining factor regarding whether services are skilled or not skilled

Reasonable & Necessary Therapy Services

- HH records must specify purpose of skilled services provided
  - Therapy services must be:
    - Reasonable & necessary to treatment of patient's illness or injury within the context of patient's unique medical condition
    - Consistent with the nature and severity of the illness or injury, the patient's medical needs, including the requirement that the amount, frequency and duration of the services must be reasonable
    - Specific, safe & effective treatment for the patients condition

Reasonable & Necessary Therapy Services

- Therapy services must also meet these standards
  - Assessment, measurement & documentation of therapy effectiveness
  - The patient's clinical condition requires the specialized skills, knowledge and judgment of a qualified therapist to establish or design a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and effectiveness of the program, to the extent provided by regulation
  - The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy

Assessment, Measurement & Documentation of Therapy Effectiveness

- Qualified therapist (not an assistant) must perform the ordered therapy service and assess the patient and document their findings in the clinical record
  - Initial therapy assessment
  - Multi-discipline: Qualified therapist from each of the disciplines must functionally reassess the patient
  - CMS has eliminated the 13th and 19th visit therapy reassessment requirements
  - Qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient

Establish or Design a Maintenance Program

- Development of maintenance program occurs during last visit(s) for rehabilitative/restorative treatment
- Goals of maintenance program would be to maintain the patient's current functional status or to prevent or slow further deterioration
- Instruction regarding maintenance program is covered if specialized skills, knowledge and judgment of qualified therapist are required and documented

Perform Maintenance Therapy

- Coverage of therapy services to perform maintenance program is determined by beneficiary's need for skilled care, not solely on their potential for improvement
  - Skilled care is necessary for performance of a safe and effective maintenance program only when:
    - Special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered nonskilled
    - Therapy procedures are of such complexity that the skills of a qualified therapist are required

Jimmo vs. Sebelius Settlement

- Coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf

Therapy Documentation

- CMS requires:
  - Assessment/evaluation
  - Treatment note for each visit
  - Reassessment documentation
  - OASIS documentation
  - POC
  - F2F encounter documentation
  - Collaboration of documentation between all entities

Assessment & Reassessment Documentation

- Clarify why patient requires “skilled” therapy to start or continue
- For reassessments, provide an estimated time frame the services will continue
- Describe illness or injury and functional deficit
- Utilize objective, functional terms
- Detail prior and current level of function
- If there has been new diagnosis or exacerbation of existing illness, date of change in condition
- Explain specific problems in detail

Amount, Frequency & Duration

- Document amount, frequency & duration of all services during each episode
- Document development, course and outcomes of skilled observations, assessments, treatment & training performed

Documenting Skilled Services & Homebound Status

- Collaborating documentation to support need for skilled therapy services and homebound status should be found in HH agency, referring, and community physician medical records
  - This information might be found in:
    - Assessments, reassessments & evaluations
    - Any and all OASIS documentation
    - History & physical exam
    - Progress notes
    - Discharge summaries
    - POC

Therapy Documentation

- Services performed
- Progress toward goals
- Patient response to administered skilled services
- Changes in patient behavior to administered skilled services
- Plan for next visit
- Skilled aspects of treatment
- Transition to home plan when services no longer require skills of therapist
- Treatment plan changes

Therapy Documentation

- Clinical notes should provide clear picture of treatment & next steps to be taken
- Documentation should not be vague or subjective; for example:
  - Patient tolerated treatment well
  - Caregiver instructed in medication management
  - Continued with POC
- Objective measurement of physical outcomes of treatment should be documented

Maintenance Therapy Documentation

- Maintenance therapy clinical notes must also describe:
  - Need for skilled service in light of patient's overall medical condition and experiences
  - Complexity of services performed
  - Pertinent characteristics of beneficiary or home

What is HH PPS?

- System of payment established by CMS to reimburse HHAs for care rendered to each beneficiary for each episode under HHA's care
- HH PPS is designated by use of 5-digit HIPPS code submitted on RAP and claim under revenue code 0023
  - HHRG from OASIS (case-mix group assigned to episode)
  - First position reflects episode sequencing and projected number of therapy visits for episode

HH PPS Reimbursement

- HH PPS payment made in two installments
  - RAP (initial payment)
    - Initial episode = 60% split (40% for final claim)
    - Subsequent episode = 50% split (50% for final claim)
  - Episode claim (final payment)
    - RAP payment recouped when final episode claim is submitted and 100% payment is made once claim processes

Supplies

- Supplies bundled into HH PPS payment
  - Routine supplies: used in small quantities for patients during usual course of home care (used in calculation of episode payment)
  - Nonroutine: needed to treat patient's specific illness or injury according to POC (reimbursement based on supply severity level)

Supplies

- Nonroutine supplies grouped based on whether supplies were or were not provided and further scaled down into severity levels
  - Note: list of nonroutine supplies can be found in the Home Health Consolidated Billing Master Code List on the CMS Web site: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html

Consolidated Billing

- HHA must bill for all HH services including:
  - Nursing and therapy services
  - Routine and non-routine medical supplies
  - HH aide services
  - Medical social services
- All HH services paid on a cost basis included in PPS rate
- Payment made to primary HHA regardless of whether or not items or services were furnished by HHA

Payment for Services

- Primary HHA is paid for all services subject to consolidated billing (i.e., all services physician has ordered under POC)
  - HHA has to have knowledge of services provided
    - Inform beneficiary about care being furnished and possible payment liability
    - Open communication with other providers of care

Requirements Prior to Billing RAP

- OASIS assessment is complete
  - Locked or export ready, or there is agency-wide internal policy establishing OASIS data is finalized for transmission to the state
- Physician's verbal orders for home care have been received and documented
- POC has been established and sent to physician
- First billable service visit under POC has been delivered

Requirements Prior to Billing Claim

- Submitted at end of 60-day period
  - Or when beneficiary is transferred or discharged
- Must be submitted after all services for episode have been provided and physician has signed POC and all verbal orders
- F2F encounter must have been completed prior to submission

How Does This Impact Therapy Billing?

- Outside therapy providers should not provide PT, OT or SLP services to a beneficiary, unless services are arranged by HHA
  - Applies to all beneficiaries under HH POC (i.e., services billed on 329 TOB)
  - Any services billed by outside therapy provider will be **rejected** due to HH consolidated billing guidelines

Initial Therapy Assessment Documentation

- For each therapy discipline, a qualified therapist (instead of an assistant) must assess patient's function using a method that objectively measures ADLs including, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors
- Measurement results must be documented in clinical record

Reassessment Documentation

- At least once every 30 days, for each therapy discipline for which services are provided, qualified therapist must functionally reassess patient
- 30-day clock begins with first therapy service
- Therapist must document measurement results in clinical record, along with therapist's determination of effectiveness of therapy, or lack thereof

Single Discipline Example

- Patient is receiving PT services 3 times/week for 3 weeks, then 2 times/week for 5 weeks
  - Some visits are provided by PTA
- Therapy begins on 5/2/15
  - 30-day reassessment must be completed on/before 5/31/15
    - Remember: For episodes beginning on or after January 1, 2015, at least every 30 calendar days, qualified therapist (not an assistant) must provide needed therapy service and functionally reassess patient

Single Discipline Example

May 2015						
SUN	MON	TUE	WED	THUR	FRI	SAT
	1	2 PT SOC	3	4 PTA	5 PTA	6
7	8 PTA	9	10 PTA	11	12 PTA	13
14	15 PTA	16	17 PTA	18	19 PT	20
21	22	23 PTA	24	25 PTA	26	27
28	29	30 PT Reassess	31	Continue PT 2 times/week as ordered		

Discipline Coding

Discipline	Revenue Code	Applicable HCPCS Code
Physical therapy	042X	G0151, G0157, G0159
Occupational therapy	043X	G0152, G0158, G0160
Speech-language pathology	044X	G0153, G0161
Skilled nursing	055X	G0154, G0162, G0163, G0164
Medical social services	056X	G0155
Home health aide	057X	G0156

Note: In the course of a single visit, a nurse or qualified therapist may provide more than one of the nursing or therapy services reflected in the codes above. HHAs must not report more than one G-code for each visit regardless of the variety of services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.

Time Reporting

Units	Minutes < means less than
1	< 23 minutes
2	= 23 minutes to < 38 minutes
3	= 38 minutes to < 53 minutes
4	= 53 minutes to < 68 minutes
5	= 68 minutes to < 83 minutes
6	= 83 minutes to < 98 minutes
7	= 98 minutes to < 113 minutes
8	= 113 minutes to < 128 minutes
9	= 128 minutes to < 143 minutes
10	= 143 minutes to < 158 minutes

Therapy Reassessment Single Discipline Billing Example

```
MAP1712        M E D I C A R E   A   O N L I N E   S Y S T E M    CLAIM PAGE 02
 SC                          INST CLAIM ENTRY                     REV CD PAGE 01

 HIC 999999999A     TOB 329   S/LOC S B0100   PROVIDER XX7XXX

                                      TOT     COV
 CL   REV   HCPC MODIFS          RATE UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT
   1  0023  1AFK1                    00060  00060         0.00               0502XX
   2  0421  G0XXX                    00005  00005       250.00               0502XX
   3  0421  Q5001                    00001  00001         0.01               0502XX
   4  0421  G0XXX                    00004  00004       150.00               0504XX
   5  0421  G0XXX                    00004  00004       150.00               0505XX
   6  0421  G0XXX                    00004  00004       150.00               0508XX
   7  0421  G0XXX                    00004  00004       150.00               0510XX
   8  0421  G0XXX                    00004  00004       150.00               0512XX
   9  0421  G0XXX                    00004  00004       150.00               0515XX
  10  0421  G0XXX                    00004  00004       150.00               0517XX
  11  0421  G0XXX                    00003  00003       100.00               0519XX
  12  0421  G0XXX                    00003  00003       100.00               0523XX
  13  0421  G0XXX                    00003  00003       100.00               0525XX
  14  0421  G0XXX                    00003  00003       100.00               0530XX

                                                                  <== REASON CODES
     PRESS PF2-171D   PF3-EXIT   PF5-UP   PF6 DOWN   PF7-PREV   PF8-NEXT   PF11-RIGHT
```

Multiple Discipline Example

- SN is ordered to start blood glucose monitoring, insulin coverage and patient education on September 8, TID AC and HS until patient able to demonstrate skills without assistance
- Patient demonstrates skill and ability to monitor and document glucose and properly draw up and inject own insulin on September 10
  - At that time, SN services are no longer medically necessary
- PT is ordered to start care on September 9, 3 times/week for 8 weeks & reassess for strengthening, endurance & patient education of exercise
- PT Reassessment is due on or before October 9.
  - In this example, reassessment would be best completed on or before October 3
- OT is ordered to start care on September 10
  - Two visits to assess patient need for assistance in home with ADLs & educate

Multiple Discipline Example

September 2015						
SUN	MON	TUE	WED	THUR	FRI	SAT
	1	2	3	4	5	6
7	8 **SN x 4 SOC**	9 **PT SOC SN x 4**	10 **OT SOC SN x 4**	11 **PTA**	12 **OT PTA**	13
14	15 **PTA**	16	17 **PTA**	18	19 **PTA**	20
21	22 **PTA**	23	24 **PTA**	25	26 **PTA**	27
28	29 **PTA**	30 **PT**				

Multiple Discipline Billing Example

```
MAP1712        M E D I C A R E   A   O N L I N E   S Y S T E M    CLAIM PAGE 02
 SC                          INST CLAIM ENTRY                     REV CD PAGE 01

 HIC 999999999A     TOB 329   S/LOC S B0100   PROVIDER XX7XXX

                                      TOT     COV
 CL   REV   HCPC MODIFS          RATE UNIT    UNIT   TOT CHARGE NCOV CHARGE SERV DT
   1 0023  1AFK1                    00060 00060          0.00               0908XX
   2 0551  G0XXX                    00005 00005        250.00               0908XX
   3 0551  Q5001                    00001 00001          0.01               0908XX
   4 0551  G0XXX                    00003 00003        200.00               0909XX
   5 0421  G0XXX                    00004 00004        150.00               0909XX
   6 0431  G0XXX                    00006 00006        200.00               0910XX
   7 0551  G0XXX                    00003 00003        125.00               0910XX
   8 0421  G0XXX                    00004 00004        150.00               0911XX
   9 0421  G0XXX                    00004 00004        150.00               0912XX
  10 0431  G0XXX                    00005 00005        175.00               0912XX
  11 0421  G0XXX                    00003 00003        100.00               0915XX
  12 0421  G0XXX                    00003 00003        100.00               0917XX
  13 0421  G0XXX                    00003 00003        100.00               0919XX
  14 0421  G0XXX                    00003 00003        100.00               0922XX

                                                                  <== REASON CODES
     PRESS PF2-171D   PF3-EXIT   PF5-UP   PF6 DOWN   PF7-PREV   PF8-NEXT   PF11-RIGHT
```

Therapy Hold Example

- Patient ordered to have PT twice/week for 3 weeks and begins therapy on 9/3
- Patient is scheduled to have surgery 9/22
  - Therapy will be held until patient has recovered sufficiently
- 30-day reassessment would normally be required by October 2nd; however, PT will be on hold at that time
  - Because agency was aware that reassessment will be required during period of hold, therapist should complete reassessment prior to hold
- In this instance, reassessment was performed on September 19
  - Last PT visit prior to therapy hold

Therapy Hold Example

September 2015						
SUN	MON	TUE	WED	THUR	FRI	SAT
	1	2	3 **PT SOC**	4 **PTA**	5	6
7	8 **PTA**	9	10	11 **PTA**	12	13
14	15	16 **PTA**	17	18	19 **PT Reassess**	20
21	22 **Surgery**	23 **Therapy hold until patient recovers**	24	25	26	27
28	29	30				

Therapy Hold Example – Reminders

- It is the responsibility of HHA to work closely with therapist and ordering physician to ensure proper communication exists
- If therapy hold is not properly communicated and HHA continues therapy services, services rendered may not be payable via Medicare

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

National Government Services Website Resources

- http://www.NGSMedicare.com
- Education Mega Tab
  - Education > Webinars, Teleconferences & Events
    - Upcoming education sessions
  - Education > Medicare University Course List
    - HH+H CBT courses
  - Education > Past Events
    - Event materials and training summaries
  - Education > Job Aids & Manuals
    - Home health and hospice billing job aids

National Government Services Website Resources

- Job Aids & Manuals
  - Highlights of the CMS Final Change Request 9119
    - Transmittal 92 & 208

National Government Services Provider Contact Center

- Provider Contact Center numbers, IVR numbers and hours of availability found under Contact Us > Provider Contact Center
  - NGSConnex
  - Written Inquiries

National Government Services 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

CMS 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 HH Services
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf
    - In accordance with its references to CMS IOM Publications 100-01 and 100-02

CMS Resources

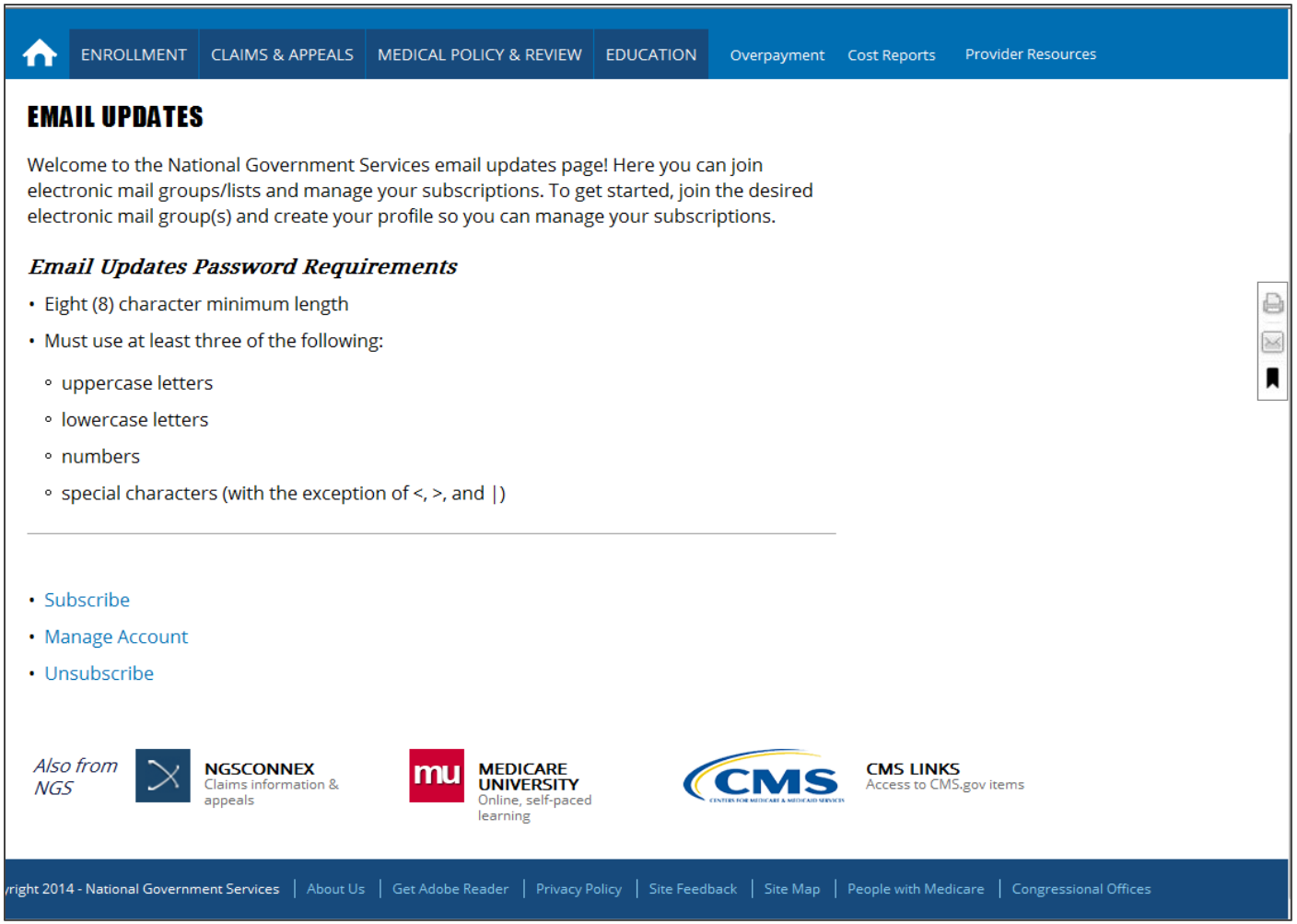
- http://www.cms.gov
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
    - Chapter 7 (Home Health Services)
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*
    - Chapter 1, Section 70, Claim Processing Timeliness
    - Chapter 1, Section 80.2, Clean Claim Submission
    - Chapter 10, Home Health Agency Billing
    - Chapter 25, UB-04 Instructions

CMS Resources

- http://www.cms.gov/center/hha.asp
  - Home Health Agency Center
    - Coding and Billing Information
    - HH PPS Regulations and Notices
    - HH Change Requests/Transmittals
    - HHA Email Updates
    - Links to OASIS information

Email Updates

- Subscribe to receive the latest Medicare information.



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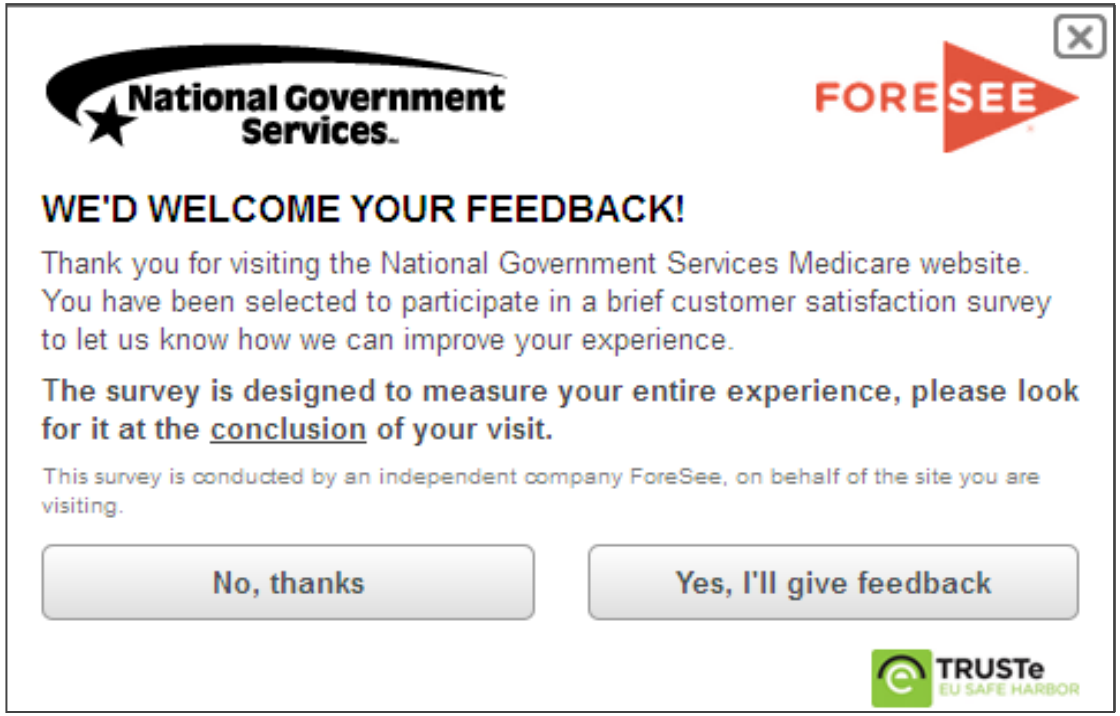

Medicare University

- 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 = **Home Health Therapy Documentation and Billing**
    - 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?