Medicare Secondary Payer – Claim Payment and Billing Beneficiaries

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Objectives

- Provide a review of
  - Which claim codes, if used incorrectly, can cause an error in MSP payment
  - How to determine if Medicare will make a secondary payment on an MSP claim
  - Payment calculations Medicare uses to determine amount of MSP payment, if any
  - How to determine beneficiary responsibility for MSP claim

Agenda

- MSP and Your MSP Responsibilities
- Submitting MSP Claims With Primary Payer's RA Coding
- MSP Claims and Coding That Can Affect Payment
- MSP Payment
- Beneficiary Responsibility on MSP Claims
- What You Should Do Now
- MSP resources – Refer to Handout
- Questions and Answers

MSP and Your MSP Responsibilities

MSP and Providers' Responsibilities

- MSP refers to
  - Situations in which beneficiary has other coverage that is primary to Medicare per federal laws known as **MSP provisions**
- Provider responsibilities
  - Identify and bill payers that are primary to Medicare before billing Medicare
  - Bill Medicare as secondary payer when required

MSP Provisions With MSP VCs and Payer Codes

MSP VC	MSP Provision	Primary Payer Code (C if conditional)
12	Working aged, 65 and over, EGHP, 20 or more employees	A
13	ESRD with EGHP in coordination period	B
14	No-Fault (automobile and other types)	D
15	Workers' Compensation or Set-Aside	E and W
16	Public Health Services; research grants	F
41	Federal Black Lung Program	H
43	Disabled, under 65, LGHP, 100 or more employees	G
47	Liability Insurance	L

Prepare and Submit MSP Claims Successfully

- Follow all steps:
  - Identify/bill appropriate primary payer for beneficiary's services
  - Upon receipt of primary payer's payment, apply it to account
  - Prepare MSP claim if necessary (partial or full payment)
  - Use correct MSP claim coding including CARC(s), RARC(s) and primary payer's adjustment amount(s) from their RA (835)
  - Ensure MSP claim information matches MSP record in CWF
    - Contact BCRC to set up or make changes to MSP record if necessary
      - Refer to MSP Resources handout for BCRC information and SE1416
    - Wait for updates to show in CWF before moving on to next step

Prepare and Submit MSP Claims Successfully

- Follow all steps (continued)
  - Review MSP claim to ensure required coding is present
  - Submit MSP claim using available options
  - Upon receipt of Medicare's payment, apply it to account
  - Apply any adjustments from Medicare's RA to account
  - Bill beneficiary only when appropriate
  - Maintain documentation

Code MSP Claims Accurately

- Follow instructions that describe how to code MSP claims
  - In CMS IOM, Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Sections 40.1 and 40.2
  - On our website under Claims & Appeals > Medicare Secondary Payer > Prepare and Submit an MSP Claim (includes MSP Billing Code chart)
- Use information you collected from beneficiary
  - During your MSP screening process and/or
  - At another other time

Claim Submission Options

- Submit MSP, tertiary and conditional claims:
  - Electronically via 837I claim,
  - In FISS DDE, or
  - Using hardcopy UB-04/CMS-1450 claim form
    - Send to our Claims Department
      - Include primary payer's RA, EOB and any other relevant information
    - You must have or obtain approved ASCA waiver
    - Visit our website for
      - ASCA information under Claims & Appeals
      - Claims address under Contact Us > P.O. Box Mailing Addresses > Claims

MSP Claim Submission via FISS DDE

- As of 1/1/2016, per CR8486, providers can
  - Use FISS DDE to
    - Submit MSP, conditional and Medicare tertiary claims
    - Correct MSP, conditional and Medicare tertiary claims
    - Adjust claims for MSP reasons
  - Submit Medicare tertiary claims via 837I claim (hardcopy submission with ASCA waiver no longer required)
- FISS process was updated to allow above actions
  - MAP1719 added to allow providers to enter payments/adjustments from CAS of primary payer's RA (835) – CAGCs, CARCs and amounts
  - MAP103L added to allow MACs to key hardcopy claims

When Submitting MSP Claims, Report Codes From Primary Payer's RA

- Medicare uses primary payer's CAGCs, CARCs and adjustment amounts when processing MSP claims for payment
  - Found in CAS segment on 835 ERA or paper RA
  - Explain why provider's billed amount was not fully paid by primary payer
  - CAGC(s) paired with CARC(s)

Reporting CAGCs and CARCs

- CAGC(s) from primary payer's RA (835)
  - Identifies general category of payment adjustment
  - Required when primary payer adjusts billed charges
  - Options:
    - CO (Contractual Obligations), OA (Other Adjustments), PI (Payer Initiated Reductions) and PR (Patient Responsibility)
- CARC(s) from primary payer's RA (835)
  - Communicates an adjustment
  - Explains why primary payer paid differently from amount billed to them
  - External Code Lists/X12
  - Examples: 1 = deductible, 2 = coinsurance, 3 = co-payment, 45 = charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

Reporting CAGCs and CARCs in FISS DDE Claim Entry Page 03 (MAP1719)

- MSP Payment Information page
  - Press <F11/PF11>, from page 03 (MAP1713), to access
  - Press <F6/PF6> to display a second page for payer 2
- Up to 20 entries each for primary payers 1 and 2
  - Field names (enter information from primary payer's RA)
    - Paid date: Enter paid date
    - Paid amount: Enter paid amount of zero (must equal amount entered for MSP VC, zero) and must equal charges less amount(s) with CAGC(s) and CARC(s)
    - GRP: Enter group code(s), also known as CAGC(s)
    - CARC: Enter CARC(s)
    - AMT: Enter dollar amount(s) associated with CAGC and CARC

Example: Reporting CAGCs and CARCs

- Medicare beneficiary
  - Working aged with EGHP primary to Medicare
  - Inpatient hospital stay from 3/1/2021 to 3/25/2021
  - Already met Part A deductible in same benefit period
- Provider
  - Charges = $10,000
  - Bills EGHP as primary; is under contract with EGHP
- EGHP
  - Allowed = $8,000 per contract
  - Applies patient coinsurance = $800
  - Paid = $7,200 on 5/15/2021

Example: Reporting CAGCs and CARCs

- Claim entry – page 01 (MAP1711)
  - MSP VC 12 = $7,200
  - MSP VC 44 = $8,000
- Claim entry – page 03 (MAP1719)
  - Paid date = 05152021
  - Paid amount = $7,200
  - CAGCs, CARCs and amounts =
    - “CO,” “45,” “$2,000” and “PR,” “2,” “$800”

MSP Claims and Coding That Can Affect Your Payment

MSP Claims

- MSP partial-pay claims
  - Submit with all Medicare covered charges as usual to have balance considered
    - Balance remains because of primary payer's application of
      - Deductible, coinsurance, copayment; noncovered services, etc.
- MSP full-pay claims
  - Submit with all Medicare covered charges as usual to meet CMS' requirements
    - Inpatient stays to track benefit period
    - Outpatient services if beneficiary has not met annual Medicare Part B deductible
    - Home health and hospice services even if beneficiary has met annual Medicare Part B deductible

General Instructions for Medicare Claims

- Follow all of Medicare's usual requirements
  - Medicare's requirements apply to all Medicare claims including MSP claims
    - Billing requirements including frequency of billing
      - Common question - Can we submit separate claims when only one claim is usually required by Medicare because the primary payer started or stopped making payment during the claim's billing period?
      - No, submit one claim as usual. The claim will be an MSP claim.
    - Technical requirements including timely filing, etc.
    - Medical requirements

Coding Your MSP Claims

- Complete claims in usual manner; report
  - Covered TOB
  - All coding usually required
  - Total covered/noncovered days as usual
  - Covered/noncovered charges as usual
  - Primary payer as first payer
  - Medicare as second payer
  - Appropriate billing codes in applicable claim fields (FLs) to indicate claim is MSP

Claim Fields and Claim Codes – MSP Claims

Code	UB-04 FLs	Electronic Field	FISS DDE
Condition codes *(02, 06 and 77)*	18–28	2300.HI (BG)	Page 01
Occurrence codes and dates *(01 to 04 and 33 with dates)*	31–34	2300.HI (BH)	Page 01
Value code and payment *(MSP VC with primary payer's payment and VC 44 with OTAF amount, if applicable)*	39–41	2300.HI (BE)	Page 01
Payer code ID *(A to L)*	N/A	N/A	Page 03
Primary insurer name (*actual name*)	50A	2320.SBR04	Page 03

Claim Fields and Claim Codes – MSP Claims

Code	UB-04 FLs	Electronic Field	FISS DDE
Insured's name	58A	2330A.NM104	Page 05
Patient's Relationship to Insured *(01,18, 19, 20, 21, 53, G8)*	59A	2320.SBR02	Page 05
Insured's unique ID	60A	2330A.NM109	Page 05
Insurance group name	61A	2320.SBR04	Page 05
Insurance group number	62A	2320.SBR03	Page 05
Insurance address	Use Remarks FL 80	Use Remarks 2300.NTE	Page 06

MSP Claim Coding That Can Affect Claim Payment

- CAS segment codes and amounts obtained from primary payer's RA
  - CAGCs and CARCs
- Condition code (CC) 77
  - Provider received full payment from primary payer
- MSP VC amount
  - Amount provider received from primary payer
- VC 44 amount
  - Amount provider expected to receive from primary payer

Contractual Arrangement or Obligation Under Law

- Provider is obligated or required to accept certain amount from primary payer as full payment
- Report on claim, as applicable, either
  - CC 77 or
  - VC 44 and OTAF (obligated to accept as payment in full) amount
    - OTAF = Amount expected from primary payer
    - Tip: Do not report both of these codes on same claim
  - Use correct CAGC(s) and CARC(s) when submitting claim

Condition Code 77

- Must report CC 77
  - When you have contractual arrangement or obligation under law and you received full expected payment
- May report CC 77
  - When you do not have contractual arrangement or obligation under law and you received full payment
- Example
  - Scenario (contractual arrangement)
    - Medicare covered charges = $5,000
    - Expected from primary payer = $4,000 and received from primary payer = $4,000
  - Report
    - Medicare-covered charges = $5,000
    - MSP VC ____ with $4,000 and CC = 77

MSP Value Codes and Amounts

- Report MSP VC for MSP provision with amount received from primary payer
  - MSP VCs: See next slide
  - Amount received from primary payer for Medicare covered services
  - Report accurate amount; do not include:
    - Payment from primary payer toward noncovered services
    - Payment from primary payer toward CMS-1500 charges
    - Contractual adjustments/write-offs between provider and primary payer
  - Use correct CAGC(s) and CARC(s) when submitting claim

MSP Value Codes for MSP Provisions

MSP VC	MSP Provision
12	Working aged, age 65 and over, EGHP, 20 or more employees
13	ESRD with EGHP in coordination period
14	No-Fault (automobile and other types)
15	Workers' Compensation or Set-Aside
16	Public Health Services; research grants
41	Federal Black Lung Program
43	Disabled, under age 65, LGHP, 100 or more employees
47	Liability Insurance

VC 44 and OTAF Amount

- Report VC 44 and OTAF amount when
  - You have a contractual arrangement or obligation under law with primary payer to receive a certain amount as full payment and
    - You received less than OTAF/expected amount from them and
    - You received less than your Medicare covered charges
- Do not report VC 44 and OTAF amount when
  - You have a contractual arrangement or obligation under law with primary payer to receive a certain amount as full payment and
    - You received less than OTAF/expected amount from them but
    - You received equal to or more than your Medicare-covered charges

Did You Know

- By reporting a VC 44 and OTAF amount, you are asking Medicare to consider the difference between the amount you were expecting to receive from the primary payer and the amount you actually received from the primary payer
  - Do not bill the beneficiary for this amount, regardless of whether or not Medicare makes an MSP payment

VC 44 Example #1

- Scenario (contractual arrangement = Yes)
  - Medicare covered charges = $5,000
  - Expected from primary payer = $4,000
    - Contractual adjustment/write-off = $1,000
  - Received from primary payer = $3,000
    - Primary payer applied deductible = $1,000

VC 44 Example #1 – Claim Coding

- Report on MSP claim:
  - Medicare covered charges = $5,000
  - MSP VC ___ and amount = $3,000
  - VC 44 and OTAF amount = $4,000
    - $4,000 calculations:
      - $5,000 – $1,000 (CO 45)
        - » Medicare covered charges – contractual adjustment/write-off
      - $3,000 + $1,000 (PR 1)
        - » Primary payment + patient's responsibility
        - » You are billing us for $1,000

VC 44 Example #2

- Scenario (contractual arrangement = Yes)
  - Medicare covered charges = $500
  - Expected from primary payer = $400
    - Contractual adjustment/write-off = $100
  - Received from primary payer = $300
    - Primary payer applied coinsurance = $100

VC 44 Example #2 – Claim Coding

- Report on MSP claim:
  - Medicare covered charges = $500
  - MSP VC ___ and amount = $300
  - VC 44 and OTAF amount = $400
    - $400 calculations:
      - $500 – $100 (CO 45)
        - » Medicare covered charges – contractual adjustment/write-off
      - $300 + $100 (PR 2)
        - » Primary payer's payment + patient's responsibility
        - » You are billing us for $100

VC 44 Example #3

- Scenario (contractual arrangement = Yes)
  - Medicare covered charges = $4,500
  - Expected from primary payer = $4,000
    - Contractual adjustment/write-off = $500
  - Received from primary payer = $3,500
    - Primary payer applied co-payment = $500

VC 44 Example #3 – Claim Coding

- Report on MSP claim:
  - Medicare covered charges = $4,500
  - MSP VC ___ and amount = $3,500
  - VC 44 and OTAF amount = $4,000
    - $4,000 calculations:
      - $4,500 – $500 (CO 45)
        - » Medicare covered charges – contractual adjustment/write-off
      - $3,500 + $500 (PR 3)
        - » Primary payer's payment + patient's responsibility
        - » You are billing us for $500

We Compare VC 44 OTAF Amount to Claim's Charges and CAGCs/CARCs

- Calculation of VC 44 OTAF amount
  - Medicare-covered charges – contractual adjustment/write-off
    - Contractual adjustments are shown on your MSP claim when you report CAGC(s) and CARC(s) from primary payer's RA (CAGC = CO)
- Per CR6426 and CR8486
  - For MSP claim to go to MSP pay module (for payment calculation)
    - VC 44 OTAF amount must = (claim's charges – CO amount)
      - If not equal, claim rejected for reason code 33981
        - » 33981: VC 44 amount and MSP calculated OTAF amount (claim's charges – CO amount) are not equal
        - » To resolve, submit new corrected claim

MSP Payment

FISS/DDE Status Locations

- You can view MSP claims in FISS/DDE once submitted and accepted
  - MSP claims in status location T B9997 = RTP
  - MSP claims in status location R B9997 = rejected
  - MSP claims in status location P B9997 = processed
    - Processed claim may or may not be paid; paid amount could be zero
      - Claim may have been considered fully paid by primary payer and no MSP payment was due
      - Has an assigned reason code
- You can view processed MSP claims on RA

MSP Payment of MSP Claims

- May be made if
  - Primary payer's payment for Medicare-covered charges is less than your charges for those services, and less than total amount payable by Medicare in absence of primary payer's payment, and
  - You do not accept or are not obligated to accept primary payer's payment as full payment for services

MSP Payment of MSP Claims

- May not be made if
  - Primary payer's payment for Medicare-covered charges equals or exceeds your charges for those services or total amount payable by Medicare (without regard to deductible or coinsurance), or
  - You accept, or are obligated to accept, primary payer's payment as full payment for services, and you receive this amount

Did You Know

- Most MSP claims are paid at the claim level. However, the MSP pay module will calculate claim payment at the line level for OPPS claims and home health LUPA claims

MSP Payment Amount

- Per CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.8.2, MSP payment amount is lowest of:
  - Gross amount payable by Medicare – (Medicare deductible + coinsurance)
  - Gross amount payable by Medicare – primary payer's payment
  - Provider's charges (or amount less than charges that provider is OTAF; VC 44 amount) – (Medicare deductible + coinsurance)
  - Provider's charges (or amount less than charges that provider is OTAF; VC 44 amount) – primary payer's payment

Did You Know

- When a primary payer pays less than your charges and less than the amount you are OTAF, we use the amount you are OTAF (VC 44 amount) in our payment calculation
  - We consider the OTAF amount to be your charges
- If you do not report a VC 44 and OTAF amount, we determine this amount
  - Charges – CO amount

MSP Payment When VC 44 Amount is Less Than Charges

- When VC 44 amount is less than charges, MSP payment amount is lowest of:
  - Gross amount payable by Medicare – (Medicare deductible + coinsurance)
  - Gross amount payable by Medicare – primary payer's payment
  - VC 44 (OTAF) amount – (Medicare deductible + coinsurance)
  - VC 44 (OTAF) amount – primary payer's payment

Revisiting VC 44 Example #1 to Show MSP Payment Amount = $500

- Let's assume
  - Gross amount payable by Medicare = $3,500
  - Part A deductible already met and no coinsurance applied
  - Payment made at claim level
- MSP payment amount is lowest of
  - $3,500 – $0 = $3,500
  - $3,500 – $3,000 = $500 (lowest)
  - $4,000 – $0 = $4,000
  - $4,000 – $3,000 = $1,000

Revisiting VC 44 Example #2 to Show MSP Payment Amount = $50

- Let's assume
  - Gross amount payable by Medicare = $350
  - Part B deductible applied; remaining = $25 and Part B coinsurance applied = $75
  - Payment made at claim level
- MSP payment amount is lowest of
  - $350 – ($25 + $75) = $250
  - $350 – $300 = $50 (lowest)
  - $400 – ($25 + $75) = $300
  - $400 – $300 = $100

Revisiting VC 44 Example #3 to Show MSP Payment Amount = $300

- Let's assume
  - Gross amount payable by Medicare = $3,800
  - Part A deductible already met; no coinsurance applied
  - Payment made at claim level
- MSP payment amount is lowest of
  - $3,800 – $0 = $3,800
  - $3,800 – $3,500 = $300 (lowest)
  - $4,000 – $0 = $4,000
  - $4,000 – $3,500 = $500

MSP Payment When VC 44 OTAF Amount is Equal to or Greater Than Charges

- When VC 44 amount is equal to or greater than charges, MSP payment amount is lowest of
  - Gross amount payable by Medicare – (Medicare deductible + coinsurance)
  - Gross amount payable by Medicare – primary payer's payment
  - Provider's charges – (Medicare deductible + coinsurance)
  - Provider's charges – primary payer's payment
- Per CR4355, we set claim as fully paid

VC 44 Example #4 – New Example

- Scenario (contractual arrangement = Yes)
  - Medicare covered charges = $4,500
  - Expected from primary payer = $6,000
    - Contractual adjustment/write-off = none; expected more than charges
  - Received from primary payer = $4,500
    - **Primary payer applied deductible = $1,500**

VC 44 Example #4 – Claim Coding Shows You are Billing Us For $1,500

- Report on MSP claim
  - Medicare covered charges = $4,500
  - MSP VC ___ and amount = $4,500
  - VC 44 and OTAF amount = Should not be reported but let's assume you reported VC 44 and $6,000
    - $6,000 calculations:
      - $4,500 + $1,500 (PR 1)
        - » Primary payer's payment + patient's responsibility
        - » **You are billing us for $1,500**

VC 44 Example #4 – Shows MSP Payment Amount = $0

- Let's assume
  - Gross amount payable by Medicare = $7,000
  - Part A deductible applies = $1,484; no coinsurance applied
  - Payment made at claim level
- MSP payment amount is lowest of
  - $7,000 – $1,364 = $5,636
  - $7,000 – $4,500 = $2,500
  - $4,500 – $1,364 = $3,136
  - **$4,500 – $4,500 = $0 (lowest)**

You May Contact our PCC if You Believe Your MSP Payment Amount is Incorrect

- Be prepared
  - Have Medicare RA and primary payer's RA available
  - Be able to provide claim coding you reported when you prepared claim
    - MSP VC and amount, VC 44 and amount and whether or not you reported CC 77
  - Be able to provide CAS segment coding you reported when you submitted claim
    - CAGCs, CARCs and associated amounts
- We may need to investigate
- We may refer you to CR6426 and/or CR8486

Beneficiary Responsibility on MSP Claims

Did You Know

- The amount we pay as secondary on an MSP claim has no affect on the amount a beneficiary owes the provider for an MSP claim

Beneficiary Responsibility on Medicare Claims

- Beneficiaries are responsible for
  - Noncovered services
  - Medicare deductible
  - Medicare coinsurance
- When Medicare is secondary, we still apply beneficiary responsibility to MSP claims
  - But, primary payer's payment is used to satisfy beneficiary's responsibility (Medicare deductible Medicare coinsurance)

Beneficiary Responsibility on MSP Claims

- Noncovered (noncovered by Medicare) services that were not paid by primary payer
- Any Medicare deductible amount + any Medicare coinsurance amount – primary payer's payment
  - Refer to CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*
    - Chapter 1, Section 40
    - Chapter 3, Section 40.1.1
    - Chapter 5, Section 40.8

Do Not Bill Beneficiaries When Not Appropriate

- Do not bill beneficiaries for
  - Amount(s) primary payer applied toward their plan deductible, coinsurance and/or co-payment
- Do not bill beneficiaries if
  - Primary payer's payment is equal to or greater than Medicare deductible and/or coinsurance applied to claim
    - Check Medicare RA for beneficiary responsibility

Revisiting VC 44 Example #1 to Show Beneficiary Responsibility = $0

- Let's assume
  - Gross amount payable by Medicare = $3,500
  - Part A deductible already met ($1,484)
  - No Medicare coinsurance applied
    - No beneficiary responsibility on MSP claim (since no deductible or coinsurance applied)

Revisiting VC 44 Example #2 to Show Beneficiary Responsibility = $0

- Let's assume
  - Gross amount payable by Medicare = $350
  - Part B annual deductible applied; remaining deductible = $25
  - Part B coinsurance applied = $75
    - No beneficiary responsibility on MSP claim (since primary payer's payment of $300 is greater than beneficiary's responsibility of $100)

Revisiting VC 44 Example #3 to Show Beneficiary Responsibility = $0

- Let's assume
  - Gross amount payable by Medicare = $3,800
  - Part A deductible already met ($1,484)
  - No Medicare coinsurance applied
    - No beneficiary responsibility on MSP claim (since no deductible or coinsurance applied)

Revisiting VC 44 Example #4 to Show Beneficiary Responsibility = $0

- Let's assume
  - Gross amount payable by Medicare = $7,000
  - Part A deductible applies = $1,484 (assume hospital stay)
  - No Medicare coinsurance applied
    - No beneficiary responsibility on MSP claim (since primary payer's payment of $4,500 is greater than beneficiary's responsibility of $1,484)

Benefit Day Utilization

- If Medicare makes a secondary payment
  - Benefit days are utilized accordingly
  - System determines number of days to deduct
- If Medicare does not make a MSP payment
  - No benefit days are utilized
  - Reference: CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 5, Section 40.8.8

Scenario and Polling Question #1

- Scenario
  - Medicare covered charges = $7,000
  - Expected from primary payer = $5,000
  - Received from primary payer = $4,000
  - Primary payer applied deductible = $1,000
  - Medicare applied deductible and coinsurance = $1,500
- Does beneficiary have responsibility for MSP claim?
  - Yes
  - No

Scenario and Polling Question #2

- Scenario
  - Medicare covered charges = $2,000
  - Expected from primary payer = $1,800
  - Received from primary payer = $300
  - Primary payer applied deductible = $1,500
  - Medicare applied deductible and coinsurance = $400
- Does beneficiary have responsibility for MSP claim?
  - Yes
  - No

What You Should Do Now

- Review MSP Resources handout
- Share information with staff
- Continue to learn more about MSP
- Continue to attend educational sessions
- Develop and implement policies that ensure your MSP responsibilities are met
- Submit accurate claims so we can make accurate payment
- Check your MSP claim payments
- Bill beneficiaries accurately

Online Assessment and Questions

- Follow-up email
  - In addition to receiving Medicare University Course Code for this webinar, attendees will be asked to complete an online assessment
- Questions?
  - Questions in Webinar question box will now be addressed
  - Contact our PCC with beneficiary/claim specific inquiries
    - Their contact information is on NGSMedicare.com under Contact Us

MSP Resources – See Handout

Education Tab on our Website

- For a complete listing of our educational activities, visit the Education mega tab on our website
- Our Education includes links to
  - Webinars, Teleconferences & Events Calendar
  - Medicare University
  - New Provider Center
  - POE Advisory Group
  - And much more
- Easiest, fastest way to be aware of POE information

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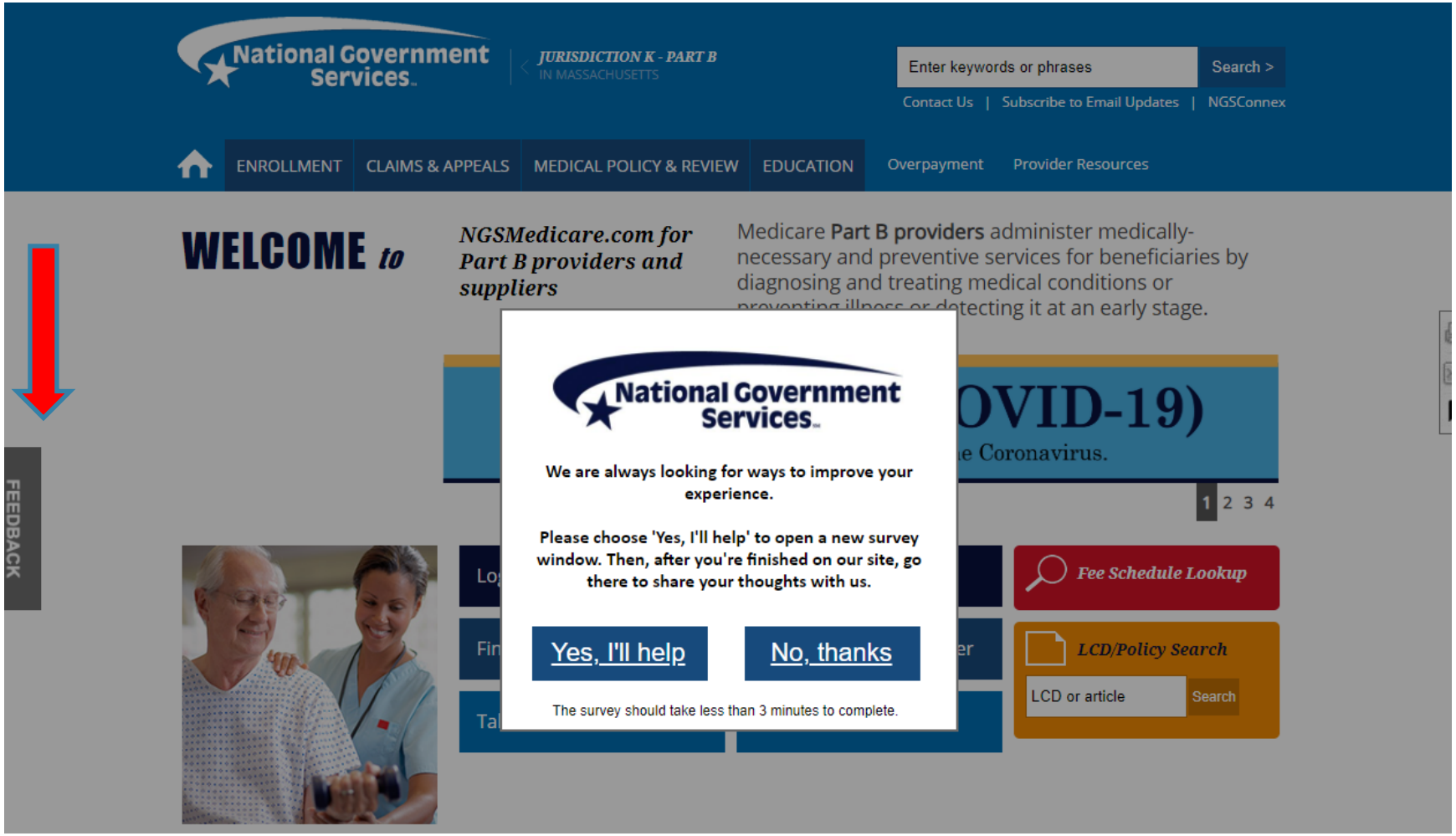

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Thank You!

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

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