MLN Connects™
Provider eNews

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Official Information Health Care Professionals Can Trust

Thursday, November 6, 2014

MLN Connects™ National Provider Calls

2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs — Registration Opening Soon

Tuesday, December 2; 1:30-3pm ET

To Register: Visit MLN Connects Event Registration. Registration will be opening soon.

This MLN Connects™ National Provider Call provides an overview of changes to the Physician Quality Reporting Programs in the 2015 Physician Fee Schedule (PFS) final rule, including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier, Physician Compare, Electronic Health Record (EHR) Incentive Program, Comprehensive Primary Care Initiative (CPC), and Medicare Shared Savings Program. A question and answer session will follow the presentations.

PQRS: Topics covered include changes to reporting mechanisms, individual measures and measures groups for inclusion in 2015, criteria for satisfactory reporting under claims-based reporting, qualified registry-based reporting, and EHR-based reporting options. Additionally, this presentation will cover satisfactory participation under the qualified clinical data registry option to avoid future payment adjustments and requirements for eligible professionals wanting to report one time across several Medicare quality reporting programs.

Value-based Payment Modifier: Learn how CMS continues to phase in and expand the application of the Value-based Payment Modifier in 2017, based on performance in 2015. CMS will also describe how the Value-based Payment Modifier aligns with the reporting requirements under the PQRS.

Agenda:

- Final rule changes to PQRS individual reporting requirements and PQRS Group Practice Reporting Option
- Final Rule Updates to Physician Compare, the EHR Incentive Program, and Value-based Payment Modifier policies
- Where to call for help
- Question and Answer Session

Target Audience: Physicians, eligible professionals, therapists, medical group practices, practice managers, medical and specialty societies, payers, and insurers.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the call detail page for more information.

National Partnership to Improve Dementia Care in Nursing Homes — Registration Now Open
Tuesday, December 9; 1:30-3pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

During this MLN Connects™ National Provider Call, speakers will discuss innovative efforts from State-based Alzheimer's Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. A question and answer session will follow the presentations.

The CMS National Partnership to Improve Dementia Care in Nursing homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings.

Agenda:

- Partnership updates

- Innovation through the Alzheimer's Association - Train the Trainer, Habilitation Therapy, and the Comfort First Approach
- Next steps

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

Certifying Patients for the Medicare Home Health Benefit — Registration Opening Soon

Tuesday, December 16; 1:30-3pm ET

To Register: Visit MLN Connects Event Registration. Registration will be opening soon.

The CY 2015 Home Health Prospective Payment System final rule finalized a new patient certification requirement for home health agencies beginning January 1, 2015. During this MLN Connects™ National Provider Call, CMS subject matter experts will discuss the changes to the Medicare home health benefit, followed by a question and answer session.

Agenda:

- Benefit overview
- Patient eligibility
- Certification requirements, including the required face-to-face encounter
- Recertification requirements
- Resources
- Q&A session

Target Audience: Physicians who certify patients for the Medicare home health benefit, hospital/Skilled Nursing Facility discharge planners, non-physician practitioners who are allowed to perform Medicare home health face-to-face encounters, and home health agencies.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

New MLN Connects™ National Provider Call Audio Recording and Transcript

An audio recording and transcript are now available for the following call:

- October 21 — Hospital Appeals Settlement Update 2, audio and transcript. More information is available on the call detail web page.

MLN Connects™ Videos

Monthly Spotlight: Medicare Preventive Services

Want to learn more about preventive services covered by Medicare? View the following featured CMS video slideshows recorded from National Provider Calls:

Initial Preventive Physical Exam and the Annual Wellness Visit, National Provider Call, 3/28/12
CMS subject matter experts provide an overview of the Initial Preventive Physical Examination (IPPE) also known as the "Welcome to Medicare" Preventive Visit, and the Annual Wellness Visit (AWV), including when to perform them, who can perform each service, eligibility, and how to code and bill for each service. A question and answer session follows the presentation. *Target audience:* Physicians, physician assistants, nurse practitioners, clinical nurse specialists, medical professionals (such as: health educators, registered dietitians, and nutrition professionals), medical billers and coders and other interested health care professionals. *Runtime:* 80 minutes. The slide presentation, written transcript, and audio recordings are available on the call detail web page.

Five New Medicare Preventive Services, National Provider Call, 8/15/12
CMS subject matter experts discuss when to perform, who can perform, eligibility, and how to code and bill for the following Medicare-covered preventive services:

- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
- Screening for Depression in Adults
- Intensive Behavioral Therapy for Cardiovascular Disease
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Intensive Behavioral Therapy for Obesity.

A question and answer session follows the presentation. *Target audience:* Primary care practitioners, medical billers and coders, and other interested health care professionals. *Runtime:* 43 minutes. The slide presentation, written transcript, and audio recordings are available on the call detail web page.

For a list of other available videos, visit the Medicare Learning Network® Playlist on the CMS YouTube Channel.

Announcements

CY 2015 Policy and Payment Changes to the Medicare Physician Fee Schedule

On October 31, CMS issued a final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2015. Medicare primarily pays physicians and other practitioners for care management services as part of face-to-face visits. Last year, CMS finalized separate payment outside of a face-to-face visit for managing the care for Medicare patients with two or more chronic conditions beginning in 2015. Through this year's rule, CMS provided more details relating to the implementation of the new policy, including payment rates. In addition, CMS adopted a new process for establishing PFS payment rates that will be more transparent and allow for greater public input prior to payment rates being set.

The final rule also makes some changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), Medicare Shared Savings Program, and Medicare Electronic Health Record (EHR) Incentive Program, as well as changes to the Physician Compare website. Finally, the rule continues the phased-in implementation of the physician value-based payment modifier (Value Modifier), created by the Affordable Care Act, that would affect payments to physicians and physician groups, as well as other eligible professionals, based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare Fee-For-Service program.

The Protecting Access to Medicare Act of 2014 provides for a zero percent PFS update for services furnished between January 1, 2015 and March 31, 2015. Current law requires physician fee schedule rates to be reduced by an average of 21.2 percent from the CY 2014 rates. In most prior years, Congress has taken action to avert a

large reduction in PFS rates before they went into effect. The Administration supports legislation to permanently change Sustainable Growth Rate (SGR) to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

The final rule includes:

- SGR
- Screening and diagnostic digital mammography
- Primary care and chronic care management
- Application of beneficiary cost sharing to anesthesia related to screening colonoscopies
- Enhanced transparency in setting PFS rates
- Potentially misvalued services
- Global surgery
- Access to telehealth services
- Adjustments to malpractice Relative Value Units (RVUs)
- Revisions to Geographic Practice Cost Indices (GPCIs)
- Services performed in off-campus provider-based departments
- Open Payments

For additional information:

- Final Rule
- Fact Sheet: Changes for CY 2015 Physician Quality Programs and Other Programs in the Medicare PFS
- Fact Sheet: Changes for the Physician Value-based Payment Modifier in CY 2015
- Open Payments website

Full text of this excerpted CMS fact sheet (issued October 31).

CY 2015 Policy and Payment Changes for ESRD Facilities and Implementation of Competitive Bidding-Based Prices for DMEPOS

On October 31, CMS issued a final rule that will update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2015. This rule also introduces new quality and performance measures to improve the quality of care by outpatient dialysis facilities treating patients with ESRD and implements the Affordable Care Act mandate to use competitive bidding rates for durable medical equipment (DME).

The ESRD and DME rule also finalizes changes to the ESRD Quality Incentive Program (QIP) for payment year (PY) 2017 and PY 2018 under which payment incentives are applied to dialysis facilities to improve the quality of dialysis care. Under the ESRD QIP, facilities that do not achieve a minimum total performance score with respect to quality measures established in regulation receive a reduction in their payment rates under the ESRD PPS. This rule also addresses issues related to the coverage and payment of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The final rule sets forth the methodology for adjusting the DMEPOS fee schedule payment amounts using information from the Medicare DMEPOS Competitive Bidding Program (CBP); establishes alternative payment rules for certain DMEPOS items for phase-in under the Medicare DMEPOS CBP; and clarifies the statutory Medicare hearing aid coverage exclusion by specifying devices not subject to the hearing aid exclusion. CMS has made a number of changes to these policies to reflect comments received on the proposed rule.

CMS projects that the ESRD bundled (ESRDB) market basket adjusted for multifactor productivity (MFP) update would have been 1.6 percent (2.1 percent ESRDB market basket update less 0.5 percent MFP adjustment). However, section 217(b) of the Protecting Access to Medicare Act of 2014 (PAMA) requires the

CY 2015 ESRD payment update to be 0.0 percent. In addition, CMS will apply a wage index budget-neutrality adjustment factor of 1.001729, resulting in a CY 2015 ESRD PPS base rate of $239.43.

The final rule includes:

- Updated payment rates for the ESRD PPS
- Updated ESRD bundled market basket adjusted for Money Follows the Person (MFP)
- Labor-related share
- Outlier policy
- Wage index
- Impact analysis
- Timing of the application of ICD-10
- Low Volume Payment Adjustment (LVPA)
- Payment for oral-only drugs under the ESRD PPS
- Defines the methodology for making national price adjustments based upon information gathered from the DMEPOS CBP
- Phase-in of special payment rules in a limited number of areas under the CBP for certain DME
- Clarification of the statutory Medicare hearing aid coverage exclusion stipulated at Section 1862(a)(7) of the Social Security Act
- Update the definition of minimal self-adjustment of orthotics at 42 CFR §414.402
- Change of ownership rules to allow contract suppliers to sell specific lines of business

For additional information:

- Final Rule
- Fact Sheet: Updating the ESRD QIP

Full text of this excerpted CMS fact sheet (issued October 31).

CY 2015 Payment and Policy Changes for Hospital Outpatient and Ambulatory Surgical Centers

CMS issued the CY 2015 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates final rule with comment period [CMS-1613-FC] on October 31.

The CY 2015 OPPS/ASC final rule with comment period updates Medicare payment policies and rates for hospital outpatient department and ASC services and partial hospitalization services provided by community mental health centers (CMHCs), and refines programs that encourage high-quality care in these outpatient settings. This rule furthers the agency's goal of delivery system reform by moving the OPPS toward making payments for larger packages of items and services rather than making separate payments for each individual service. This reform provides incentives for facilities to deliver more efficient, higher quality care. In CY 2015, CMS is implementing a policy finalized last year regarding comprehensive Ambulatory Payment Classifications (C-APCs), with some refinements and updates. The new C-APC payment policy makes a single payment for all related or adjunctive hospital items and services provided to a patient receiving certain primary procedures that are either largely device dependent, such as insertion of a pacemaker, or represent single session services with multiple components, such as intraocular telescope implantation.

Overall OPPS payments are estimated to increase by 2.3 percent for CY 2015. The increase is based on the projected hospital market basket increase of 2.9 percent minus both a 0.5 percentage point adjustment for multi-factor productivity and a 0.2 percentage point adjustment required by law and includes other payment changes, such as increased estimated total outlier payments.

The final rule includes:

- OPPS payment update
- C-APCs
- Items and services to be "packaged" or included in payment for a primary service, including ancillary services, prosthetic supplies, and skin substitutes
- Off-campus provider-based departments
- Hospital outpatient outlier payment
- CMHC outlier payment
- Part B drugs in the outpatient department
- ASC payment update
- Partial Hospitalization Program (PHP) rates
- CMS-identified overpayments associated with Medicare Advantage and Part D submitted payment data
- Revision of the requirements for physician certification of hospital inpatient services

For additional information:

- Final Rule
- Fact Sheet: CMS Finalizes Hospital Outpatient and ASC Quality Reporting Program Changes for 2015

Full text of this excerpted CMS fact sheet (issued October 31).

CY 2015 Payment Changes for Medicare Home Health Agencies

On October 30, CMS announced changes to the Medicare Home Health Prospective Payment System for CY 2015 that will foster greater efficiency, flexibility, payment accuracy, and improved quality. Approximately 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies, costing Medicare approximately $18 billion in 2013.

In the rule, CMS projects that Medicare payments to home health agencies in CY 2015 will be reduced by 0.30 percent, or $60 million. This decrease reflects the effects of the 2.1 percent home health payment update percentage ($390 million increase) and the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor (2.4 percent or $450 million decrease).

The rule implements increases to the national per-visit payment rates, a 2.82 percent reduction to the NRS conversion factor, and a reduction to the national, standardized 60-day episode rate of $80.95 for CY 2015. The national, standardized 60-day episode payment for CY 2015 is $2,961.38.

The final rule includes:

- Face-to-face encounter requirements
- Therapy reassessments
- Rate-setting changes
- Home Health Quality Reporting Program update
- Conditions of participation for speech-language pathologists
- Home Health Value-based Purchasing model

For additional information:

- Final Rule
- Home Health Prospective Payment System website

Full text of this excerpted CMS fact sheet (issued October 30).

Raising Awareness of Diabetes in November

During the month of November, the United States draws attention to diabetes and its impact on public health through several national health observances, including National Diabetes Month, Diabetic Eye Disease Month, and World Diabetes Day – November 14. Millions of Americans have diabetes and don't know it. Left undiagnosed or untreated, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney disease, amputation, and even premature death. However, with early diagnosis and treatment people with diabetes can take steps to control the disease and lower the risk of complications. CMS asks that you join us in increasing awareness of diabetes by talking with your patients about their risk factors. Additionally, you can reinforce the importance of early detection and treatment to prevent or delay many associated illnesses. You can also provide your patients referrals and appropriate documentation in order to utilize the appropriate Medicare-covered services. Read more.

Final Rule Changes for Open Payments

Since Open Payments implementation in February 2013, CMS has encouraged and received feedback from the public regarding certain aspects of the reporting requirements for the final rule and program development. Based on this feedback, four revisions have been published as part of the 2015 Medicare Physician Fee Schedule final rule. These revisions were effective as of October 31, 2014, and will be implemented for the 2016 program year, with reporting to CMS in 2017.

- Deletion of the definition of "covered device"
- Deletion of the Continuing Education Exclusion in its entirety
- Required reporting of the marketed name and therapeutic area or product category of the related covered drugs, devices, biologicals, or medical supplies, unless the payment or other transfer of value is not related to a particular covered or non-covered drug, device, biological or medical supply
- Required reporting by applicable manufacturers of stocks, stock options, or any other ownership interest as distinct categories

Reminder: Based on public comments, specific changes to 42 C.F.R. Part 403, subpart I, Transparency Reports and Reporting of Physician Ownership or Investment Interests, will be implemented for the 2016 program year, with reporting to CMS in 2017.

Learn more about the final rule changes and to understand how you may be impacted:

- Law and Policy web page on the Open Payments website
- Fact Sheet: Policy and payment changes to the Medicare Physician Fee Schedule for 2015
- Final Rule

Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act

On October 31, CMS released the results of its decisions regarding which teaching hospitals are receiving increases to their Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) full-time equivalent (FTE) resident caps under Round 6 of section 5506 of the Affordable Care Act. Section 5506 directed CMS to develop a process to permanently preserve and redistribute the Medicare funded residency slots from teaching hospitals that close. Priority is given to hospitals located in the same or contiguous Core Based Statistical Areas (CBSAs) as the closed hospital, and that meet other criteria.

Round 6 of section 5506 redistributes the residency slots of Cooper Green Mercy Hospital in Birmingham, AL and Sacred Heart Hospital in Chicago, IL. A list of hospitals reviewed under Round 6 of section 5506 is available on the Direct Graduate Medical Education web page.

CMS is Accepting Suggestions for Potential PQRS Measures

CMS is accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. Quality measures submitted in this Call for Measures may also be considered for use in other quality programs for physicians and other eligible professionals (e.g. Value Based Modifier, Physician Compare, Medicare Shared Savings Program, etc.).

The PQRS Call for Measures is now conducted in an ongoing open format, remaining open indefinitely. The month that a measure is submitted for consideration will determine when it may be included on the Measures Under Consideration (MUC) list. Measures submitted prior to June 15, 2015 may be considered for inclusion on the 2015 MUC list for implementation in PQRS as early as 2017.

CMS will give priority to measures that are outcome-based, answer a measure gap, and address the most up-to-date clinical guidelines. Measures submitted for consideration will be assessed to ensure that they meet the needs of the PQRS. As time permits, feedback will be provided to measure submitters upon review of their submission. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Additionally, CMS is *not* accepting claims-based only reporting measures in this process. Note that measures already included in previous PQRS MUC lists may only be re-submitted for consideration if the measure has undergone substantive changes.

Each measure submitted for consideration *must* include all required supporting documentation. Documentation requirements and the submission timeline are posted on the Measures Management System Call for Measures web page Questions about this Call for Measures or the required documentation may be submitted to C4M@wvmi.org.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the PQRS. Additionally, measures submitted for consideration are not guaranteed to be put forth on the MUC list for Measures Application Partnership (MAP) review. CMS will determine which individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the PQRS.

Comparative Billing Report on Modifier 25: Family Practice

CMS will issue a national provider Comparative Billing Report (CBR) on family practice providers' use of Modifier 25 in November 2014. The CBR, produced by CMS contractor eGlobalTech, will focus on family practice providers and will contain data-driven tables and graphs with an explanation of findings that compare these providers' billing and payment patterns to those of their peers in their state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. These reports are only accessible to the providers who receive them; they are not publicly available.

Providers should update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating CBRs. Providers can contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com if they prefer to receive CBRs through the U.S. Postal Service. For more information, please contact the CBR Support Help Desk, or visit the CBR website.

Medicare Learning Network® Educational Products

"Medicare Appeals Process" Podcast — New

The "Medicare Appeals Process" Podcast is now available. This podcast is designed to provide education on the five levels of claim appeals in Original Medicare (Medicare Part A and Part B). It includes details explaining how the Medicare appeals process applies to providers, participating physicians, and participating suppliers in addition to including more information on available appeals-related resources.

"Skilled Nursing Facility Prospective Payment System" Fact Sheet — Revised

The "Skilled Nursing Facility Prospective Payment System" Fact Sheet (ICN 006821) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Skilled Nursing Facility Prospective Payment System (SNF PPS). It includes the following information: background and elements of the SNF PPS.

"Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet — Revised

The "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet (ICN 006847) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS). It includes the following information: background, elements of the IRF PPS, payment updates, and IRF Quality Reporting Program.

Medicare Learning Network® Products Available in Electronic Publication Format

The following products are now available as electronic publications (EPUBs) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at "How To Download a Medicare Learning Network® Electronic Publication."

- The "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports" Educational Tool (ICN 909008) is designed to provide education on ground and air ambulance coverage and billing requirements that apply to destinations covered under the Medicare ambulance transport benefit. It includes the following information: the ambulance transport benefit, ambulance providers and suppliers, documentation requirements, coverage and billing requirements, and Advance Beneficiary Notice of Noncoverage.
- The "Medicare Billing Information for Rural Providers and Suppliers" Booklet (ICN 006762) is designed to provide education on Medicare rural billing. It includes information for Critical Access Hospitals, Federally Qualified Health Centers, Home Health Agencies, Rural Health Clinics, Skilled Nursing Facilities, and Swing Beds.
- The "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" Fact Sheet (ICN 903196) is designed to provide education on three Medicare programs. It includes an overview of the HPSA Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs.
- The "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet (ICN 906223) is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A Home Health Agency, Part B, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) beneficiary services.

- "Internet-based PECOS FAQs" Fact Sheet (ICN 909015) is designed to provide education on Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). It includes information on many frequently asked questions related to enrollment applications, application fees, revalidations and much more.
- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet (ICN 909017) is designed to provide education on how to ensure Medicare enrollment records are up-to-date and secure. It includes step-by-step instructions on how providers can protect their identity while using Internet-based PECOS.
- The "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet (ICN 006827) is designed to provide education on preventing, detecting, and reporting Medicare fraud and abuse. It includes fraud and abuse definitions, as well as an overview of the laws used to fight fraud and abuse; descriptions of the government partnerships engaged in preventing, detecting, and fighting fraud and abuse; and resources on how providers can report suspected fraud and abuse.
- The "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet (ICN 006903) is designed to provide education on the Medicare Secondary Payer (MSP) provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, the Coordination of Benefits rules, and the role of the Benefits Coordination & Recovery Center.

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